

11540

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>DISTRICT of Columbia</u> b. COUNTY <u>47X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write "RURAL and give nearest town") <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u> <u>3700</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Marie Lillian</u> First Middle Last		4. DATE OF DEATH Month <u>10</u> Day <u>28</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 18, 1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>Switzerland</u>
13. FATHER'S NAME <u>Solomon Richard Frey</u>		14. MOTHER'S MAIDEN NAME <u>Rosalie Weber</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> <u>527.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic pulmonary fibrosis</u> (c) <u>emphysema</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hr</u> <u>yes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerotic cardiovascular disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>25 Oct, 1959</u> to <u>28 Oct, 1959</u> (that I last saw the deceased alive on <u>23 Oct, 1959</u> ), and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Horace W. Bernton, M.D.</u> <u>10511 Summit Ave., Kensington, Md.</u>			
ACTUAL SIGNATURE			
PHYSICIAN'S NAME (Type) <u>Horace W. Bernton, M.D.</u> <u>10511 Summit Ave., Kensington, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial-Removal</u>	<u>10-30-59</u>	<u>Cedar Hill Cemetery Suitland</u>	<u>Prince Georges Co</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jos. Pawler's Sons Inc. 1756 P. Ave. NW</u>		24a. REC'D BY REGISTRAR <u>OCT 30 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u> Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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[illegible]

## CERTIFICATE OF DEATH

11486

Reg. Dist. No.

11541

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Dist. of Columbia</u> b. COUNTY <u>Columbia</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md.</u>		c. LENGTH OF STAY IN 1b <u>87 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ranier Sanatorium &amp; Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Isabella</u> Middle <u>Addison</u> Last <u>Addison</u>		4. DATE OF DEATH Month <u>10</u> / Day <u>31</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/25/1875</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U. S. Govt. Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clerical</u>	11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Watkins Addison, Jr.</u>	
14. MOTHER'S MAIDEN NAME <u>Margaret Dodge</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> (If yes, give war or date of service) <u>W. W. 1</u>	
16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Hospital Record</u> Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> <u>30 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Lobar pneumonia</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 1959, to <u>10/31</u> , 1959, that I last saw the deceased alive on <u>10/29</u> , 1959, and that death occurred at <u>9:50</u> A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1728 Mass Ave N.W.</u> DATE SIGNED <u>  </u>			
ACTUAL SIGNATURE <u>John W. Latimer, Jr.</u> M.D.		PHYSICIAN'S NAME (Type) <u>John W. Latimer, Jr.</u> <u>Washington D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/3/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph F. Burck's Son</u> ADDRESS <u>3034 E. St. N. W. Wash., D.C.</u>		24a. RECEIVED BY REGISTRAR DATE <u>NOV 3 59</u> 24b. REGISTRAR'S SIGNATURE <u>  </u>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>	c. LENGTH OF STAY IN lb <b>6 years</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> <b>47x.3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Gardens</b>		e. STREET ADDRESS <b>2006 Columbia Rd., N. W.</b>	f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ELLA</b> Middle <b>V.</b> Last <b>ALLNUTT</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>31,</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 21, 1873</b>
9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months <b>8</b> Days <b>10</b>	IF UNDER 24 HRS. Hours <b>10</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Charles Thomas</b>		14. MOTHER'S MAIDEN NAME <b>Annie Jones</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Daughter Mrs. Thomas Perry</b>		18. ADDRESS <b>3510 Raymoor Rd. Kensington, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> 334x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Rt. hemiplegia</b> DUE TO (c) <b>Cerebral arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>7 yrs. 20 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1948</b> , 19 <b>59</b> , to <b>31 Oct. 59</b> , that I last saw the deceased alive on <b>31 Oct.</b> , 19 <b>59</b> , and that death occurred at <b>5:00 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1726 M Street, N. W.</b> DATE SIGNED ACTUAL SIGNATURE <b>Charles W. Thompson</b> M.D. PHYSICIAN'S NAME (Type) <b>CHARLES W. THOMPSON</b> <b>Washington, D. C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-2-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Monocacy Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Beallsville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>		ADDRESS <b>Bethesda, Md.</b>	24a. REC'D BY REGISTRAR DATE <b>NOV 4 '59</b>
		24b. REGISTRAR'S SIGNATURE <i>Charles E. Thomas</i>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF TEXAS

1882

January 1st

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11543

## CERTIFICATE OF DEATH

Reg. Dist. No.

11488

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>				c. LENGTH OF STAY IN 1b <b>35 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY COUNTY GENERAL HOSPITAL</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LAYTONSVILLE</b>			
				f. STREET ADDRESS <b>1</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>FRANCES</b> Last <b>ALLNUTT</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>20</b> Year <b>19 59</b>					
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/8/90</b>	9. AGE (In years lost birthday) <b>69</b> yrs.	IF UNDER 1 YEAR Months <b></b> Days <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Navy Dept. Bureau Of Docks</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>WILLIAM DOUGLAS BELL</b>				14. MOTHER'S MAIDEN NAME <b>IDA FIDELIA WARFIELD</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>218 38 6131</b>		17. INFORMANT <b>HOSPITAL RECORDS</b> Address <b>OLNEY, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Leukemia, Granulocytia</b> 204.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b> DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b>5 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month <b></b> Day <b>19</b> Year <b>1959</b> Hour a. m. <b></b> p. m. <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>9-15</b> , 19 <b>59</b> to <b>10-20</b> , 19 <b>59</b> that I last saw the deceased alive on <b>10-20</b> , 19 <b>59</b> , and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>GAITHERSBURG, MARYLAND</b> DATE SIGNED <b>10-20-59</b>							
ACTUAL SIGNATURE <b>Jack Schumacher</b> M.D.							
PHYSICIAN'S NAME (Type) <b>J. SCHUMACHER, M. D.</b>		<b>GAITHERSBURG, MARYLAND</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Oct. 22 59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Laytonsville</b>	22d. LOCATION (City, town, or county)	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Roy W Barber</b>		ADDRESS <b>Laytonsville, Md.</b>	24a. REC'D BY REGISTRAR <b>OCT 26 59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1122

CHARTERED IN DEATH

1912

NOTES

REMARKS

REMARKS

LAVERVILLE

22 MAY

22 MAY

REMARKS - THE 1st LATERAL

22 MAY 1912

REMARKS

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11544

## CERTIFICATE OF DEATH

Reg. Dist. No 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN Tb <b>27 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Michigan</b> b. COUNTY <b>Detroit</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>59X-3</b> d. STREET ADDRESS <b>17159 Van Buren Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Frances Mary ANDERSON</b>			4. DATE OF DEATH Month Day Year <b>October 7 19 59</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-13-05</b>	9. AGE (In years last birthday) <b>53</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Colorado</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			13. FATHER'S NAME <b>Harley FRINK</b>				
14. MOTHER'S MAIDEN NAME <b>Madge RUSSELL</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service) <b>No</b>				
16. SOCIAL SECURITY NO. <b>INFORMANT</b>			17. <b>Naval Research Institute Beth.Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma toxic</b> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of R. breast</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>10 Sept 19 59</b> to <b>7 October 1959</b> that I last saw the deceased alive on <b>7 October 19 59</b> , and that death occurred at <b>8:35 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>C.W. Bramlett</b>		M.D. <b>U.S. Naval Hospital, Bethesda Md.</b>					
PHYSICIAN'S NAME (Type) <b>C.W. BRAMLETT LT MC USN</b>		<b>U.S. Naval Hospital, Bethesda Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>10-10-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodmere Crematory</b>			
22d. LOCATION (City, town, or county) (State) <b>Livonia, Wayne, Michigan</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumphrey</b>		24a. REC'D BY REGISTRAR <b>13 '59</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>		25. ADDRESS <b>1357 Wisconsin Ave. Bethesda Md.</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10-10-50, Woodward County, Virginia, Washington

U.S. Naval Hospital, Bethesda Md.

U.S. Naval Hospital, Bethesda Md.

U.S. Naval Hospital, Bethesda Md.

U.S. Naval Hospital, Bethesda Md.

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U.S. Naval Hospital, Bethesda Md.

U.S. Naval Hospital, Bethesda Md.

U.S. Naval Hospital, Bethesda Md.



11490

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

11545

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN lb <b>208 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>				d. STREET ADDRESS <b>Rd4</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Elizabeth Dejean ANNER</b>				4. DATE OF DEATH Month Day Year <b>October 9 19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-21-19</b>	9. AGE (In years lost birthday) <b>39 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>		11. BIRTHPLACE (State or foreign country) <b>Florida</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Henry ANNER</b>				14. MOTHER'S MAIDEN NAME <b>Leisla SINGLETON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>486 22 5656</b>		INFORMANT <b>(Walter Anner (Uncle))</b>		Address <b>Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Multiple Hemorrhages</b> <b>12.4</b> DUE TO (b) <b>Aplastic Anemia</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>24 hrs</b>						INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2 Feb</b> , 19 <b>59</b> , to <b>9 October</b> , 19 <b>59</b> that I last saw the deceased alive on <b>9 October</b> , 19 <b>59</b> , and that death occurred at <b>4:04 AM</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>R. G. Muth</b>				ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda Md.</b>			
PHYSICIAN'S NAME (Type) <b>R. G. MUTH LT MC USN</b>				U.S. Naval Hospital, Bethesda Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-10-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Prince George Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur A. Thomas</b>				24a. REC'D BY REGISTRAR <b>Oct 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur A. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11491

Reg. Dist. No.

11546

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>5 yr</u>				d. STREET ADDRESS <u>313 North West Dr</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>313 North West Dr</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Joseph Aloysius Ashie</u>				4. DATE OF DEATH <u>Oct 19 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-14-1893</u>	
9. AGE (in years last birthday) <u>65 yrs.</u>		IF UNDER 1 YEAR Months <u>6</u> Days <u>5</u>		IF UNDER 24 HRS. Hours <u>2</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>N.Y. City</u>			
11. BIRTHPLACE (State or foreign country) <u>N.Y. City</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Abraham Ashie</u>				14. MOTHER'S MAIDEN NAME <u>SADA ASSAD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>W.W.I.</u>				16. SOCIAL SECURITY NO. <u>111-11-1111</u>			
17. INFORMANT <u>June Ashie (wife)</u>				Address <u>Stem 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u></u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u></u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Hour <u></u> a. m. <u></u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Brochart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BROCHART</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10-19-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-22-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u> ADDRESS <u>WASH. D. C. 3821 14TH. ST. N.W.</u>				24a. REC'D BY REGISTRAR <u>OCT 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.



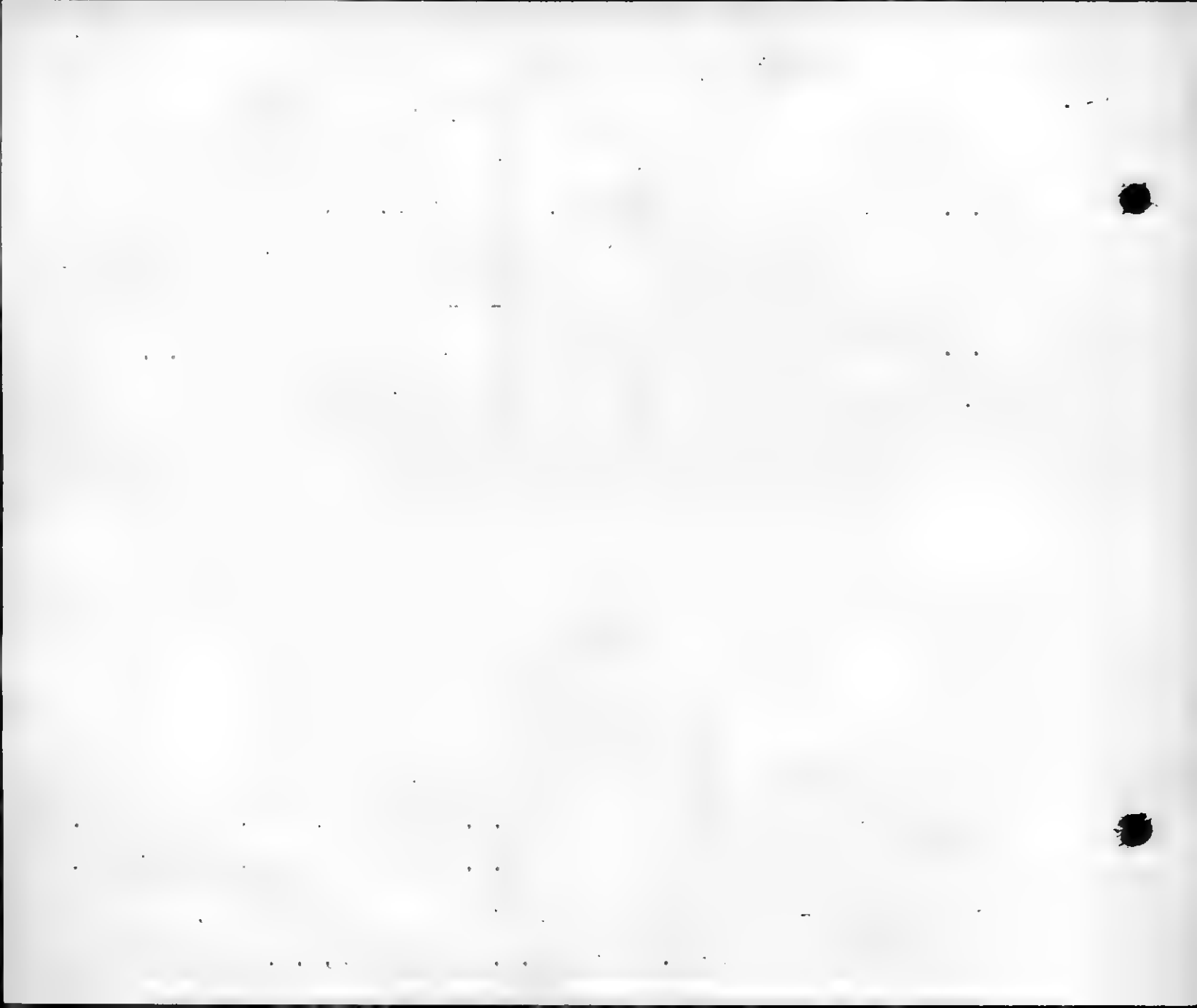
11547

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>42 days</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>District of Columbia</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>3133 Conn. Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Frank (n) BALDWIN</b>		4. DATE OF DEATH Month Day Year <b>October 19 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-19-1880</b>
9. AGE (In years last birthday) <b>78</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>	
11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Henry BALDWIN</b>		14. MOTHER'S MAIDEN NAME <b>Julia BORREBS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WWL&amp;II</b>	
17. INFORMANT <b>Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral arteriosclerosis</b> <b>334X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Esophageal diverticulum</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7 September 59</b> to <b>19 October 19 59</b> , that I last saw the deceased alive on <b>19 October 19 59</b> , and that death occurred at <b>7:07 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda Md.</b> 10-14-59 ACTUAL SIGNATURE <b>Francis J. Linch</b> M.D. <b>U.S. Naval Hospital, Bethesda Md.</b> PHYSICIAN'S NAME (Type) <b>U.S. Naval Hospital, Bethesda Md.</b>			
22a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-22-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Gawlers</b>		24a. REGISTER'S SIGNATURE <b>10-14-59</b>	
24b. REGISTER'S SIGNATURE <b>10-14-59</b>		24c. REGISTER'S SIGNATURE <b>10-14-59</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

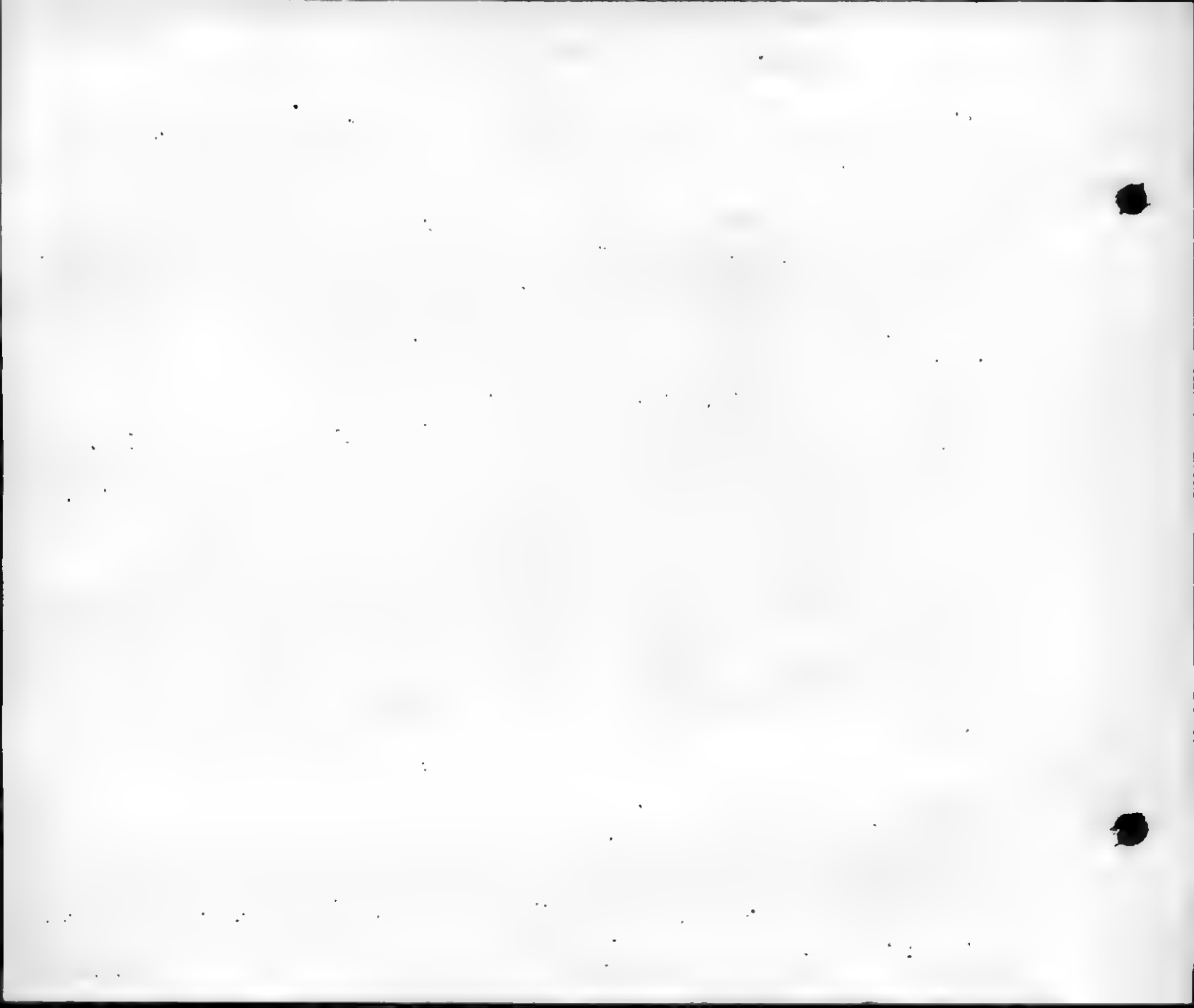
11493

CERTIFICATE OF DEATH

Reg. Dist. No.

11548

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Echo Hyatts</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x Glen Echo Hyatts</b> d. STREET ADDRESS <b>12 Wyoming Court</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Coy</b> Middle <b>T</b> Last <b>Barefoot</b>		4. DATE OF DEATH Month <b>Oct</b> Day <b>17</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>w</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 11, 1890</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>6</b> Hours <b>1</b> Min <b>0</b>	11. IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cab Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILEY T BAREFOOT</b>		14. MOTHER'S MAIDEN NAME <b>Mary Tart</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO <b>XXXXXXXX-XX-XXXX</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intestinal obstruction</b> DUE TO <b>Emergency of 9 U. S. Roadster</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Intestinal obstruction</b> DUE TO <b>Intestinal obstruction</b> (c) <b>Intestinal obstruction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 1/2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>2:30</b> a. m. <b>Oct 17 1959</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 17, 1959</b> , to <b>Oct 17, 1959</b> , that I last saw the deceased alive on <b>Oct 17, 1959</b> , and that death occurred at <b>2:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>John C. Murphy</b> M.D.			
PHYSICIAN'S NAME (Type) <b>John C. Murphy</b> <b>4630 Montgomery Ave., Bethesda, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<b>BURIAL</b>		<b>10-21-59</b>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>PARKLAWN CEMETERY</b>		<b>ROCKVILLE MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Co</b>		24a. REC'D BY REGISTRAR <b>3072 M-ST NW</b> <b>Wash, D.C.</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>		24c. DATE <b>OCT 20 '59</b>	



## CERTIFICATE OF DEATH

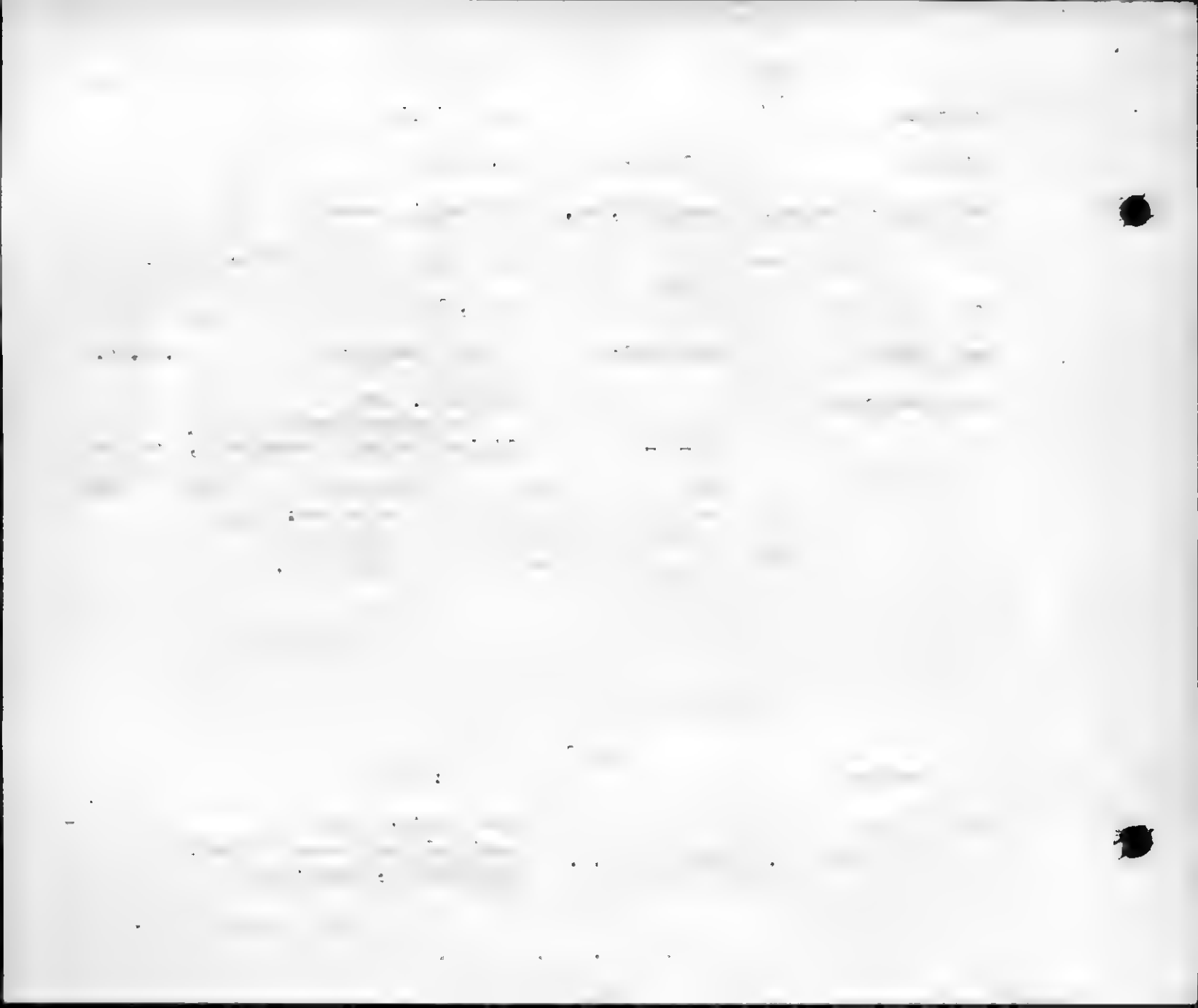
Reg. Dist. No.

11549

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>101 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>West Virginia</b>		b. COUNTY <b>Charleston</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>902 Morris Street</b>		4. DATE OF DEATH Month <b>October</b>		Day <b>26</b>		Year <b>1959</b>			
3. NAME OF DECEASED (Type or print) First <b>Orange</b>		Middle <b>Lee</b>		Last <b>Barksdale</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>June 9, 1884</b>		9. AGE (In years last birthday) <b>75</b> yrs.		10. FUND 1 YEAR Months <b>1</b>		11. FUND 24 HRS Days <b>26</b>		12. FUND 24 HRS Hours <b>1</b>		13. FUND 24 HRS Min. <b>59</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Coal Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Mining</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Issac Barksdale</b>		14. MOTHER'S MAIDEN NAME <b>Dochie A. Lee</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>232-28-5601</b>		INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of stomach with metastases to liver, retroperitoneal tissue, and vertebrae; and carcinoma of right maxillary antrum with metastases to meninges and middle ears.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>19</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Date nature of injury in Part I or Part II of item 18.) <b>19</b>		20c. TIME OF INJURY Month <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>19</b>	
20f. (City or town) <b>19</b>		(County) <b>19</b>		(State) <b>19</b>		21. I certify that I attended the deceased from <b>July 17, 1959</b> to <b>October 26, 1959</b> that I last saw the deceased alive on <b>October 26, 1959</b> and that death occurred at <b>8:05 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>19</b>		DATE SIGNED <b>10-26-59</b>			
ACTUAL SIGNATURE <b>Edward D. McLaughlin</b>		M.D. <b>The Clinical Center</b>		NATIONAL INSTITUTES OF HEALTH <b>Bethesda 14, Maryland</b>		PHYSICIAN'S NAME (Type) <b>Edward D. McLaughlin, M.D.</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/29/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill</b>		22d. LOCATION (City, town, or county) <b>Charleston, W. Va.</b>		22e. (State) <b>19</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>For: Brooks &amp; Allen Funeral Home</b>		24a. REC'D BY REGISTRAR <b>OCT 29 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove tabular papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

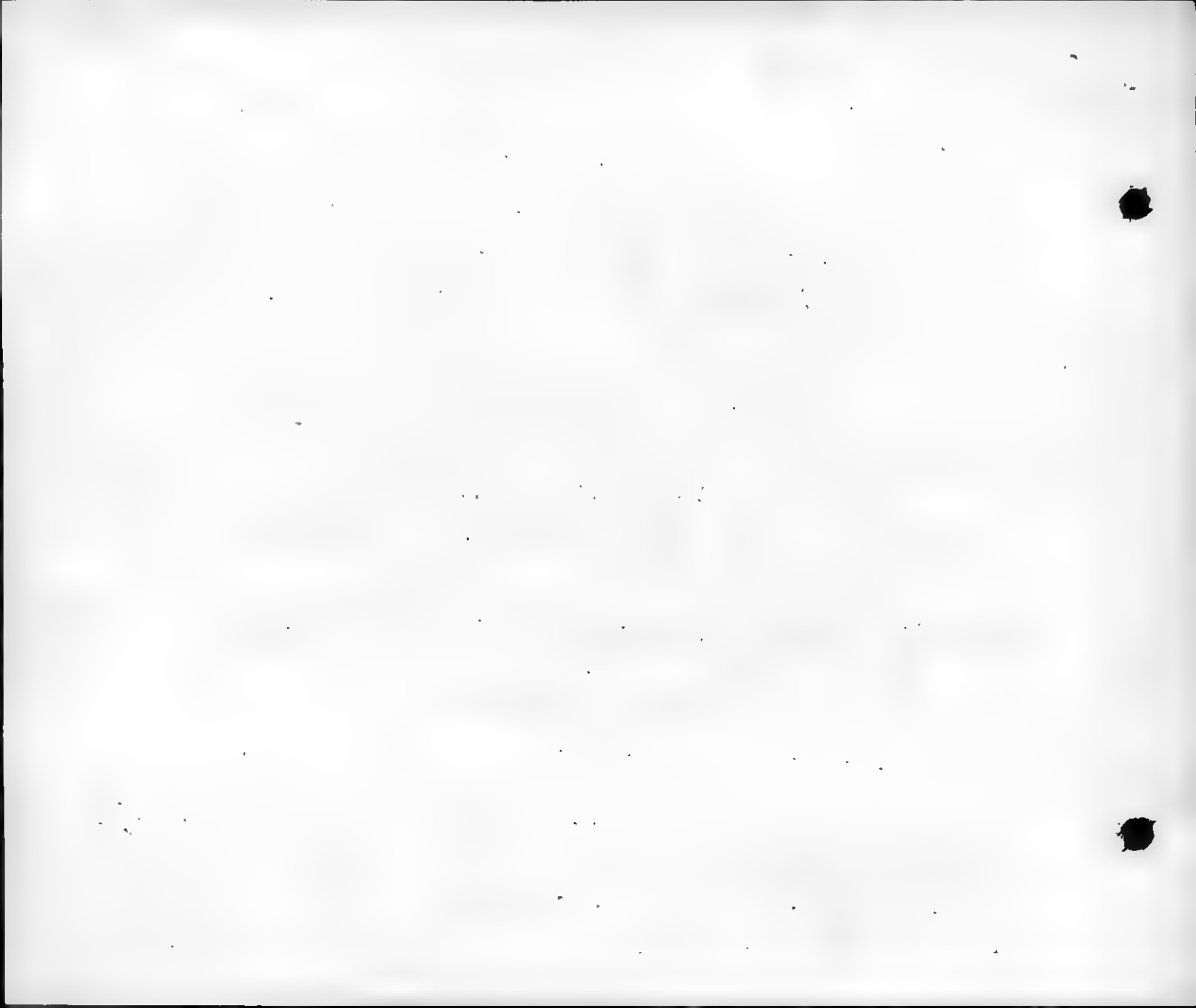
Reg. Dist. No.

11550

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DEXTERSDALE</u> c. LENGTH OF STAY IN 1b <u>18 DAYS</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DEXTERSDALE</u> d. STREET ADDRESS <u>3316 MONTGOMERY AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EUGENE</u> Middle <u>S.</u> Last <u>BARRY</u>		4. DATE OF DEATH Month <u>11</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-11-1879</u>
9. AGE (In years last birthday) <u>80 yrs</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	11. IF UNDER 24 HRS Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TANNER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TANNING</u>	
11. BIRTHPLACE (State or foreign country) <u>MASS.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>EUGENE BARRY</u>		14. MOTHER'S MAIDEN NAME <u>LUCY INYMAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>018-10-5792</u>	
17. INFORMANT <u>JANE DALSLY</u>		Address <u>3316 MONTGOMERY AVE. DEXTERSDALE, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cardiovascular disease</u> DUE TO (c) <u>no</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>colostomy, release of intestinal obstruction</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>10 yrs</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>no</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 2</u> , 19 <u>59</u> , to <u>Oct 6</u> , 19 <u>59</u> that I last saw the deceased alive on <u>at 6/59</u> , 19 <u>59</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7930 Georgia Ave Silver Spring</u> DATE SIGNED <u>Oct 7/59</u>			
ACTUAL SIGNATURE <u>John O. Robben</u>		PHYSICIAN'S NAME (Type) <u>John O. Robben</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>10-7-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>Oct 8 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles E. House</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## CERTIFICATE OF DEATH

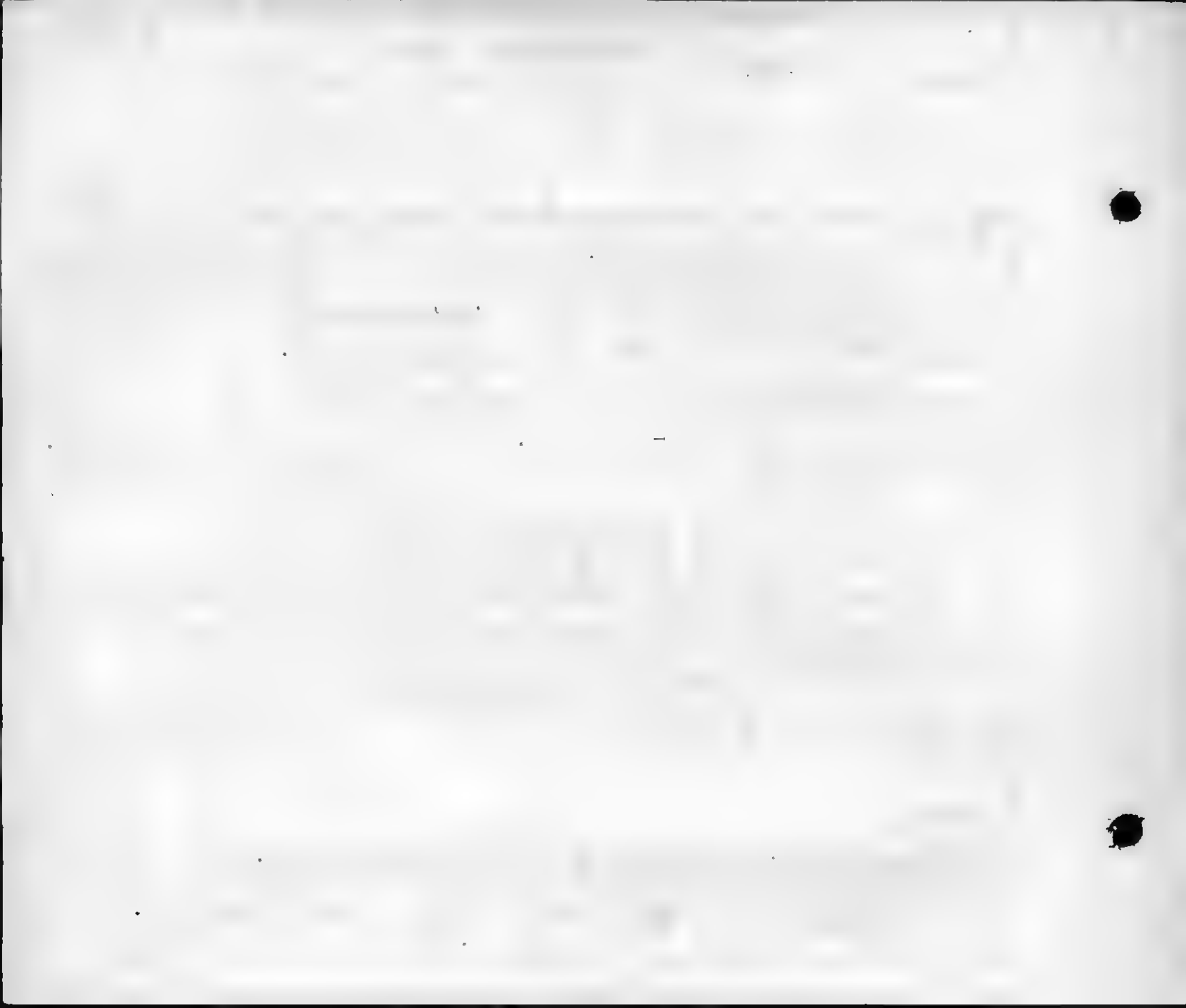
Reg. Dist. No.

11551

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Germantown</b>				c. LENGTH OF STAY IN 1b <b>years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RFD # 1, Box 54</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Celeste</b> Middle <b>Pearl</b> Last <b>Beall</b>				4. DATE OF DEATH Month <b>October</b> Day <b>23</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 16, 1901</b>	9. AGE (In years last birthday) <b>57</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Cedar Grove, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Lee Watkins</b>				14. MOTHER'S MAIDEN NAME <b>Minnie A. King</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Wm. E. Beall, Box 54, Germantown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intestinal obstruction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>metastatic Carcinoma</b> DUE TO (c) <b>Carcinoma ovary</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b> <b>6 mo.</b> <b>18 mo</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>April</b> <b>1958</b> , to <b>Oct 23</b> <b>1959</b> , that I last saw the deceased alive on <b>Oct 22</b> <b>1959</b> , and that death occurred at <b>12:05 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Vernon E. Martens</b> M.D. <b>Germantown, Md.</b>				DATE SIGNED <b>Oct 24, 59</b>			
PHYSICIAN'S NAME (Type) <b>Vernon E. Martens</b> <b>Germantown, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/26/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Upper Seneca Baptist</b>		22d. LOCATION (City, town, or county) (State) <b>Cedar Grove, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Oliver L. Johnson</b>		ADDRESS <b>Damascus, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 28 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 shows, is detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11497

## CERTIFICATE OF DEATH

11503

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Interlaken Bk.</u>		c. LENGTH OF STAY IN 1b <u>1 mth</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Everetide Nursing Home</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Spencerville RR Interlaken</u>	
		d. STREET ADDRESS <u>1</u>	
		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Rural</u> First <u>T</u> Middle <u>J</u> Last <u>Beardsley</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>23</u> Year <u>19-7</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-May 26, 1884</u>
9. AGE (In years last birthday) <u>25</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel T. Jordan</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Prince</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Records</u>	
17. INFORMANT <u>Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>445 X Cardiac Insufficiency</u> DUE TO <u>Cardiac Enlargement</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u> <u>5 yrs.</u> <u>24 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/23/1959</u> to <u>10/23/1959</u> , that I last saw the deceased alive on <u>10/23/1959</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert F. Hare</u> M.D.		ADDRESS (Street, city or town, state) <u>7600 Carroll Dr. 701 Park Md.</u> DATE SIGNED <u>10/23/59</u>	
PHYSICIAN'S NAME (Type) <u>Robert F. Hare Md.</u>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 27, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lakeside Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>HOLLY, MICHIGAN</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Walters</u> ADDRESS <u>259 Carroll St. D.C.</u>		24a. REC'D BY REGISTRAR <u>10/26/59</u> 24b. REGISTRAR'S SIGNATURE <u>W. Walters</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11498

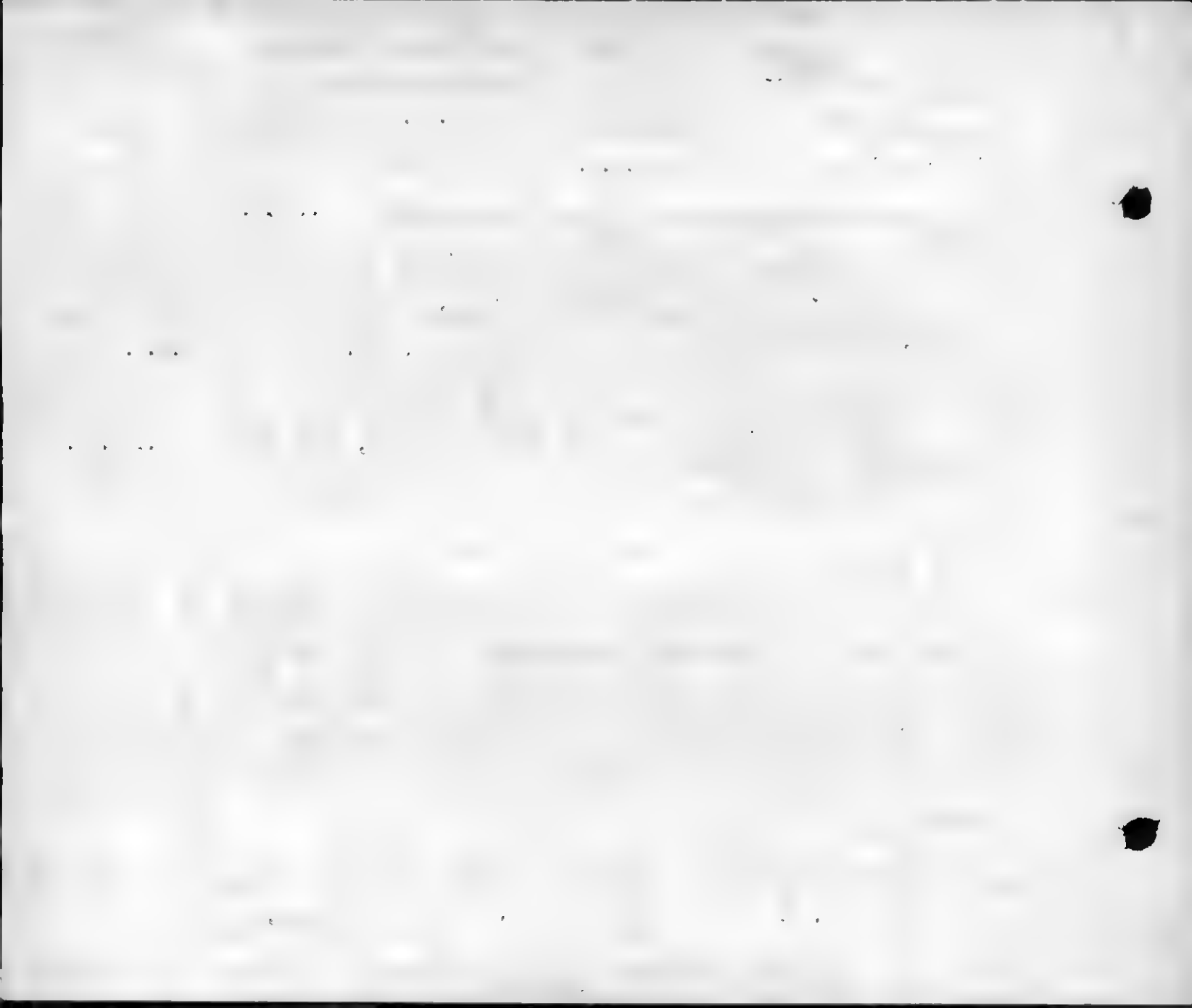
Reg. Dist. No.

11552

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		d. STREET ADDRESS <b>312 Quackenbos St., N.W.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Silver Theatre</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Aaron</b> Middle <b>Gilbert</b> Last <b>Berch</b>		4. DATE OF DEATH Month <b>10</b> Day <b>28</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 6, 1913</b>
9. AGE (In years last birthday) <b>46</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>7</b>	IF UNDER 24 HRS. Hours <b>10</b> Min. <b>59</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waiter</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Chicago, Ill.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Aaron Gilbert Berch</b>		14. MOTHER'S MAIDEN NAME <b>Ada Lucas</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>7/7/43 1/31/46</b>	
17. INFORMANT <b>Olga Berch Woods</b>		Address <b>1342 Randolph St., N. W.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral concussion</b> 910.6 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Fracture of skull</b> (c) <b>Fall down stairs</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>few minutes</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Fall down stairs at Silver Theatre</b>	
20c. TIME OF INJURY Month, Day, Year <b>10-28-59</b> Hour <b>11</b> o. m. <b>pm</b>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Theatre</b>	20f. (City or town) <b>Silver Spring</b> (County) <b>Montgomery</b> (State) <b>MD</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Frank J. Broschert</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>FRANK J. BROSCHE</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>10-28-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 3, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l. Cem.</b>	22d. LOCATION (City, town, or county) <b>Arlington, Virginia</b> (State)
23. FLUNERAL DIRECTOR'S SIGNATURE <b>John J. ...</b>		24a. REC'D BY REGISTRAR <b>NOV 2 '59</b>	
ADDRESS <b>...</b>		24b. REGISTRAR'S SIGNATURE <b>C. ...</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.





11553

CERTIFICATE OF DEATH

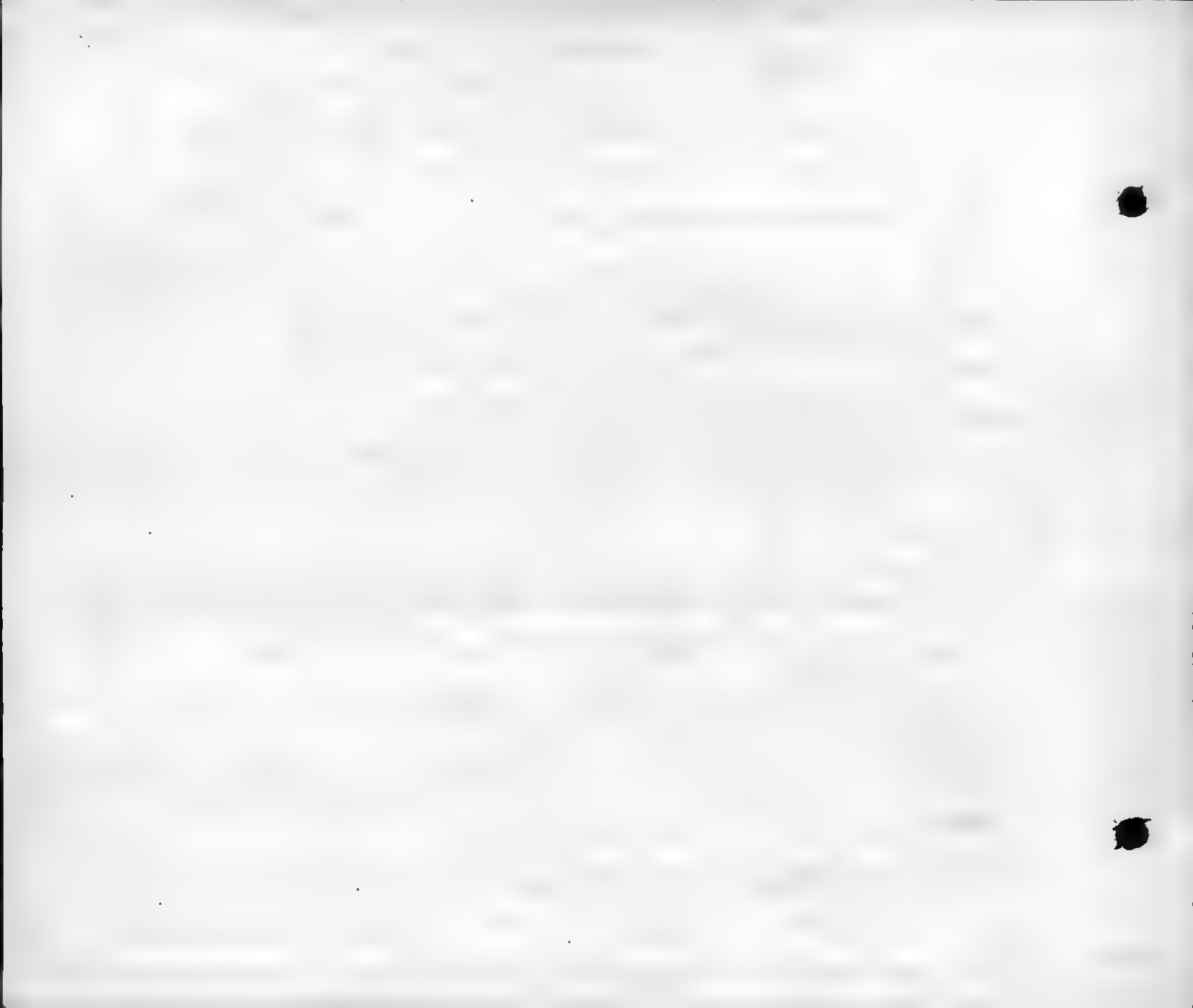
11499

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <i>DC</i> b. COUNTY <i>Washington</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Fairland</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Fairland Hospital</i>		d. STREET ADDRESS <i>1426 Sheridan St. NW</i>	
3. NAME OF DECEASED (Type or print) <i>Sda</i> First <i>Berger</i> Middle Last		4. DATE OF DEATH Month <i>Oct</i> Day <i>16</i> Year <i>1959</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1872</i> June 16 1872
9. AGE (In years last birthday) <i>87</i> yrs.		IF UNDER 1 YEAR: Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House duties</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Austria</i>	
11. BIRTHPLACE (State or foreign country) <i>Austria</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Benjamin</i>		14. MOTHER'S MAIDEN NAME <i>Bertha</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>082-05-7356</i>	
17. INFORMANT <i>Helen Friedlander</i>		Address <i>1426 Sheridan St. NW</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Longstanding heart failure - acute</i> <i>443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive + arteriosclerotic heart mag. yrs?</i> <i>Dissecting</i> DUE TO (c) <i>Generalized arteriosclerosis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>March</i> , 1957, to <i>10/16</i> , 1957, that I last saw the deceased alive on <i>10/15</i> , 1957, and that death occurred at <i>7:15</i> A.M. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <i>Washington DC</i>		DATE SIGNED <i>10/16/59</i>	
ACTUAL SIGNATURE <i>Benjamin Isaacson</i> M.D.			
PHYSICIAN'S NAME (Type) <i>Benjamin Isaacson</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>10/18-1959</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Vernon</i>	22d. LOCATION (City, town, or county) (State) <i>Ross Island Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Goldberg Funeral Home Wash. D.C.</i>		24a. REC'D BY REGISTRAR DATE <i>OCT 19 1959</i>	
ADDRESS <i>Washington D.C.</i>		24b. REGISTRAR'S SIGNATURE <i>William S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the original papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



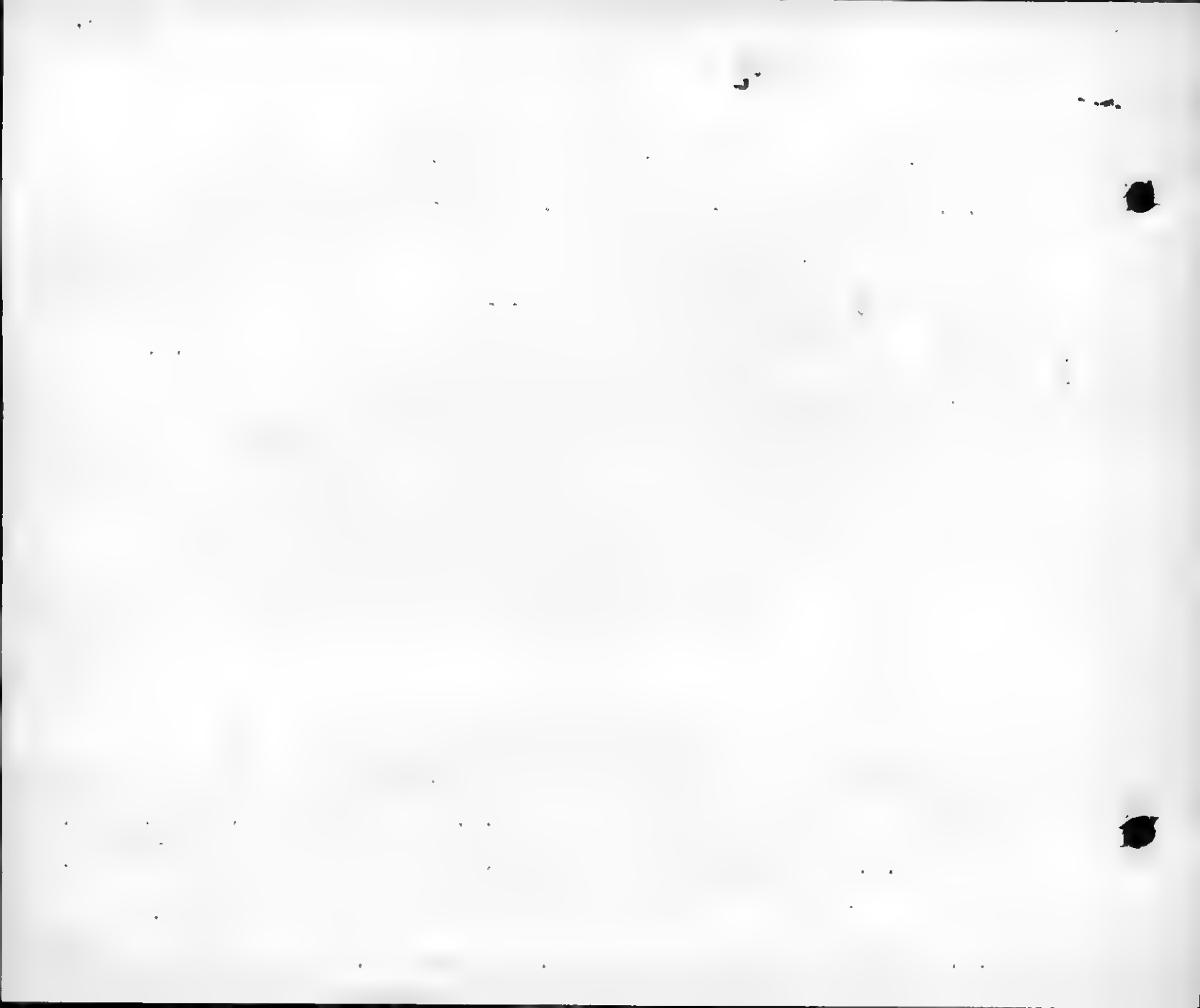
11554

## CERTIFICATE OF DEATH

11500

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>13 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Res dence before admission) a. STATE <b>Louisiana</b> b. COUNTY <b>Winnfield</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Winnfield</b> d. STREET ADDRESS <b>305 East Court Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Dwanna Ruth BERRY</b>				4. DATE OF DEATH Month Day Year <b>October 22 19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-3-56</b>	
9. AGE (In years last birthday) <b>3</b> yrs		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Louisiana</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Norwood Dale BERRY</b>				14. MOTHER'S MAIDEN NAME <b>Betty Holward</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT Address <b>(Father) Norwood Berry Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>754.5</b> <b>CONGENITAL HEART DISEASE, (Atrial Septal Defect, anomalous pulmonary venous return)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Past surgical correction status</b> (c) <b>Past surgical correction status</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>INTERVAL BETWEEN ONSET AND DEATH</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9 October, 19 59</b> to <b>22 October, 19 59</b> that I last saw the deceased alive on <b>22 October, 19 59</b> and that death occurred at <b>8:45 AM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>J. E. McClenathan</b> <b>U.S. Naval Hospital, Bethesda Md.</b> ACTUAL SIGNATURE M.D. <b>10-22-59</b> PHYSICIAN'S NAME (Type) <b>J. E. MC CLENATHAN CDR MC USN U.S. Naval Hospital, Bethesda Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-27-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Winnifield Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Winnifield La.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Pumphrey</b>				ADDRESS <b>7557 Wisconsin Ave. Bethesda Md.</b>		24a. REC'D BY REGISTRAR <b>OCT 27 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

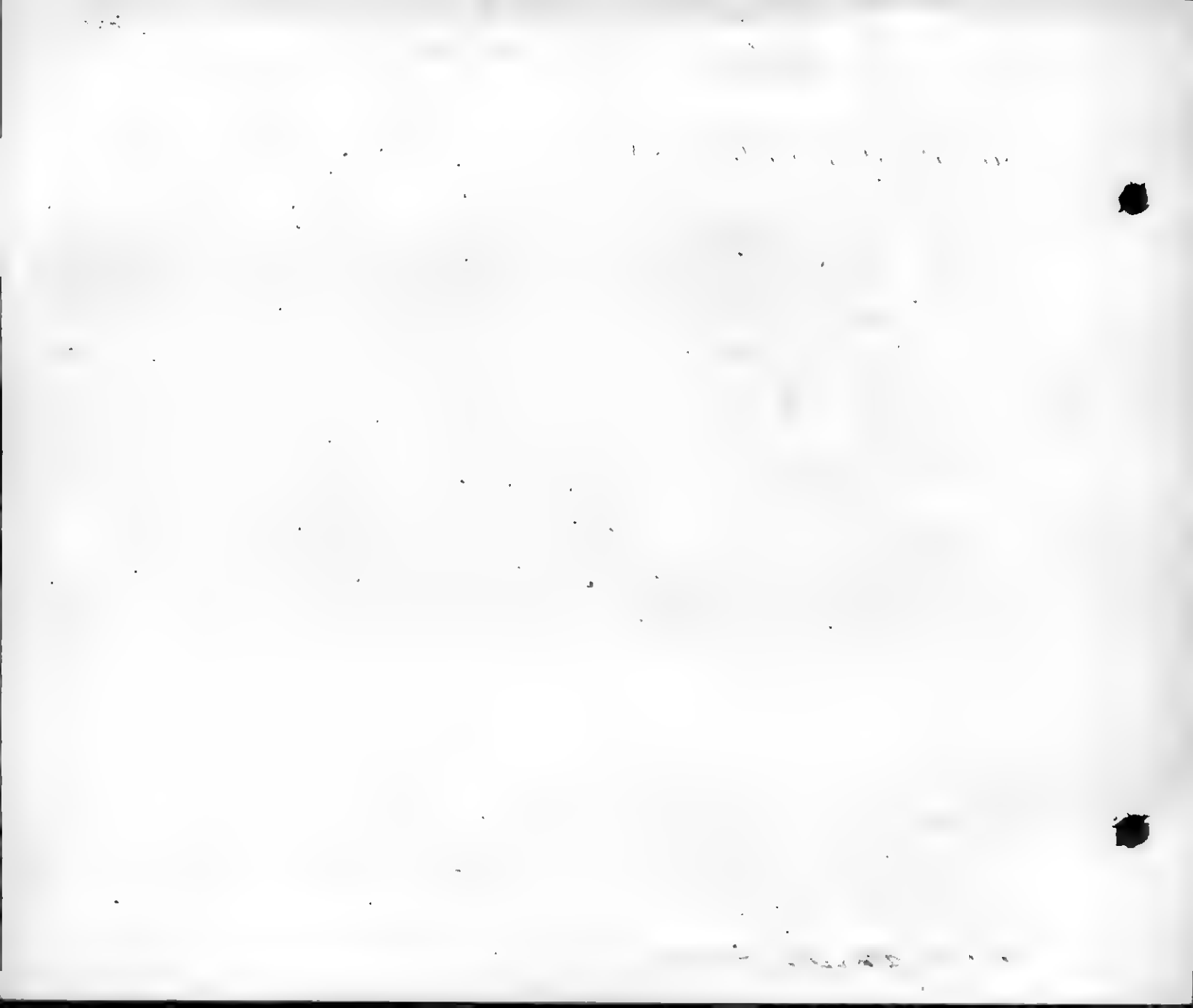


11555

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>D.C.</b> b. COUNTY <b>1</b>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>WASHINGTON</b>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Washington 15</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Nathan</b> Middle <b>Block</b> Last <b>Block</b>		4. DATE OF DEATH Month <b>OCT</b> Day <b>18</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 16, 1914</b>
9. AGE (In years last birthday) <b>65 yrs.</b>		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>3</b> Hours <b>15</b> Min.	11. IF UNDER 24 HRS Months <b>6</b> Days <b>3</b> Hours <b>15</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>D.C. Court-Bldg Inspector</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Missouri</b>	
11. BIRTHPLACE (State or foreign country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Paul Block</b>		14. MOTHER'S MAIDEN NAME <b>Celia Miller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>486-16-6005</b>	
17. INFORMANT <b>Mary J Block</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>pulmonary edema</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>congestive heart failure</b> DUE TO <b>myocardial infarction, acute</b> lying cause (c) <b>diabetes mellitus</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2-3 hrs</b> <b>3-4 hrs</b> <b>5-6 hrs</b> <b>17 year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT. ON GIVEN IN PART I (a) <b>diabetes mellitus</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>o. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat white <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 18, 1958</b> to <b>10/18, 1959</b> that I last saw the deceased alive on <b>10/18, 1959</b> and that death occurred at <b>12:45</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Charles J. Savarese</b> M.D.		ADDRESS (Street, city or town, state) <b>4890 Batry Lane, Beth. Md.</b>	
PHYSICIAN'S NAME (Type) <b>CHARLES J. SAVARESE, JR. M.D.</b>		DATE SIGNED <b>10/18/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>BURIAL</b>	<b>OCT 20, 1959</b>	<b>ST. LOUIS</b>	<b>MO.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Dangelosky &amp; Sons</b>		24a. REC'D BY REGISTRAR <b>Wash DC</b>	
ADDRESS <b>3501-14 St NW</b>		24b. REGISTRAR'S SIGNATURE <b>Charles J. Savarese</b>	
DATE <b>OCT 21 '59</b>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

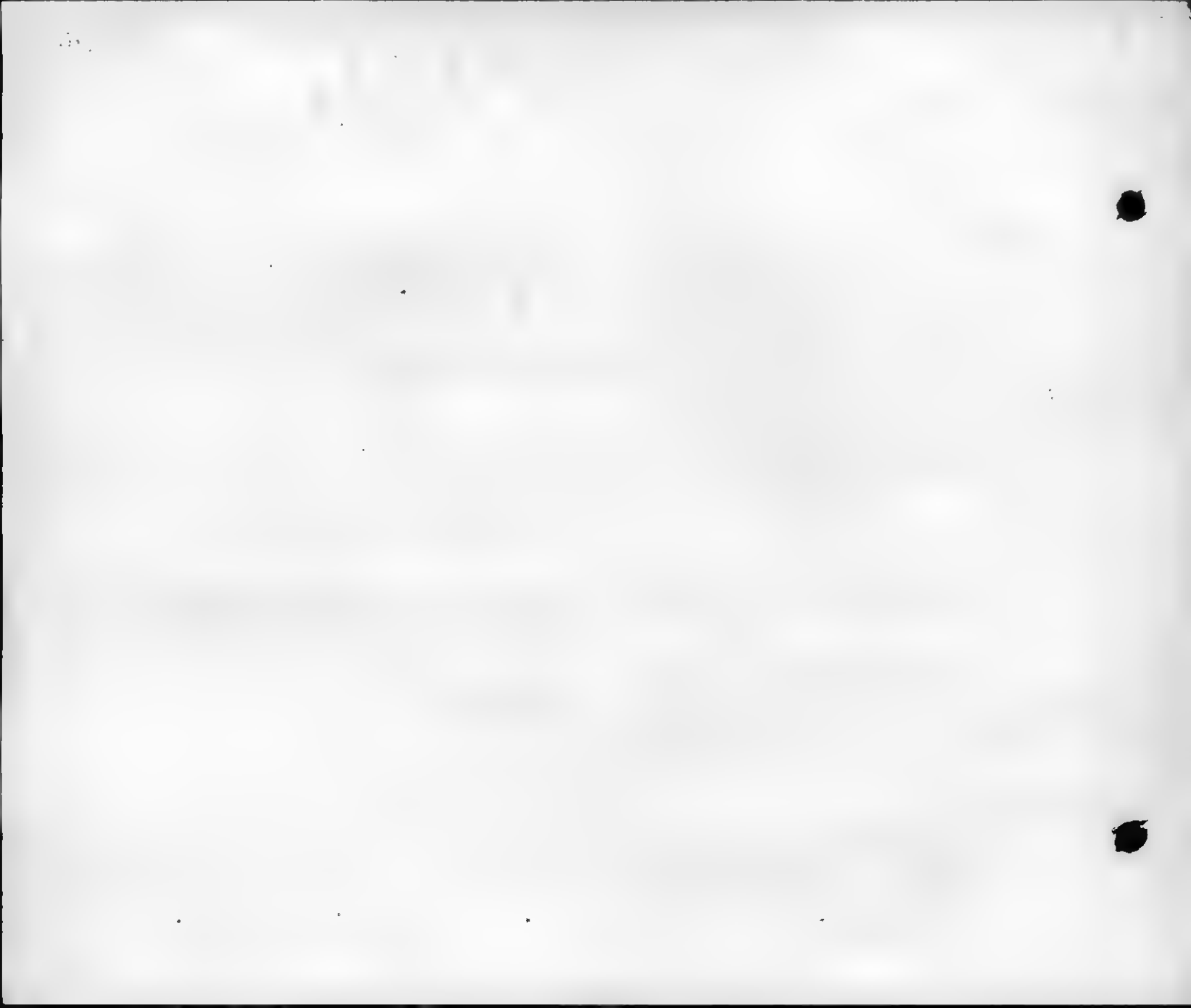
11502

11556

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>1 wk.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookeville</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Harvey</u> Middle <u>W.</u> Last <u>Boswell</u>				4. DATE OF DEATH Month <u>10</u> Day <u>6</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 6</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>19</u>	IF UNDER 24 HRS Hours <u>19</u> Min. <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postmaster</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Postmaster</u>		11. BIRTHPLACE (State or foreign country) <u>Gaithersburg, Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Rodney Boswell</u>				14. MOTHER'S MAIDEN NAME <u>Jenkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>+</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Hospital Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> 17" X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ventricular Fibrillation</u> DUE TO (c) <u>Prostatic Ca + Cachexia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u> <u>16 hrs</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>April</u> , 1953, to <u>10-6-</u> , 1959, that I last saw the deceased alive on <u>10-6-</u> , 1959, and that death occurred at <u>3:30</u> PM, from the causes and on the date stated above							
ACTUAL SIGNATURE <u>John Booby Ziegler</u> M.D.				ADDRESS (Street, city or town, state) <u>Olney, Md.</u>		DATE SIGNED <u>6 Oct 59</u>	
PHYSICIAN'S NAME (Type) <u>John Booby Ziegler</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct. 9, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Salem Meth.</u>		22d. LOCATION (City, town or county) (State) <u>Brookeville, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ray W. Zieher</u> ADDRESS <u>Salemville Md.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 9 '59</u>	24b. REGISTRAR'S SIGNATURE <u>C. L. Kline</u>		





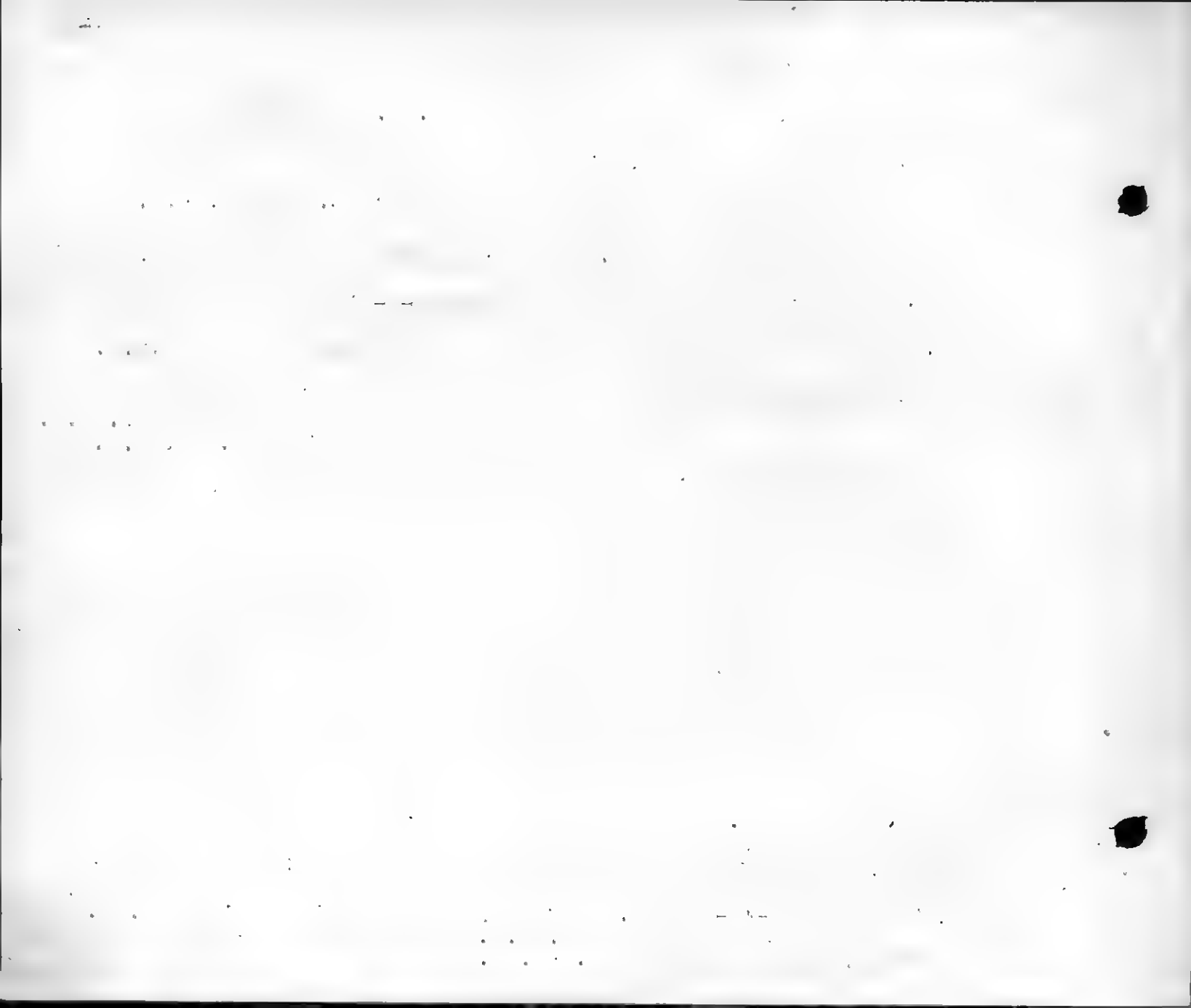
11532

## CERTIFICATE OF DEATH

11503

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCKVILLE</b> c. LENGTH OF STAY IN lb <b>2 MONTHS</b>		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4618 IRIS PLACE</b>		d. STREET ADDRESS <b>501 12th. STREET, N.E.</b>	
3. NAME OF DECEASED (Type or print) <b>ETHEL B. BRODERICK</b>		4. DATE OF DEATH Month <b>10</b> Day <b>8</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT 9-7-93</b>
9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JEFFERSON BOWEN</b>		14. MOTHER'S MAIDEN NAME <b>BLANCHE PEED</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>JOHN BRODERICK 501 12th. St. N.E.</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Pancreas</b> <b>157x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>7:00 10/8/59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8-1-1959</b> to <b>10/8-1959</b> , that I last saw the deceased alive on <b>10/7-1959</b> , and that death occurred at <b>7:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>301 Constitution St. Wash. D.C.</b> DATE SIGNED <b>W. H. B.</b>			
ACTUAL SIGNATURE <b>A. Keene Bowie</b>		SIGNATURE OF REGISTRAR <b>W. H. B.</b>	
PHYSICIAN'S NAME (Type) <b>A. KEENE BOWIE</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>10-12-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D. C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis J. Collins</b>		24a. REC'D BY REGISTRAR <b>OCT 19 1959</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>



## 11557 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>VIENNA</u>	
c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		d. STREET ADDRESS <u>R.F.D. #1 Box 163</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>St. Clair</u> Middle <u>Brookes Jr.</u> Last		4. DATE OF DEATH Month <u>10</u> Day <u>13</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 18, 1888</u> yrs. <u>71</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Law</u>	
11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN ST. CLAIR BROOKES, SR.</u>		14. MOTHER'S MAIDEN NAME <u>LUCY NEWTON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Police record</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Collapsed while playing golf at Burning Tree C.C.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .	
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>10-13-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>10/15/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>IVY HILL CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>ALEXANDRIA, VA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Rawlers &amp; Sons, Inc.</u> ADDRESS <u>1756 Pa. Ave., N.W.</u>		24a. REC'D BY REGISTRAR <u>DC OCT 16 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Clifton L. Evans</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

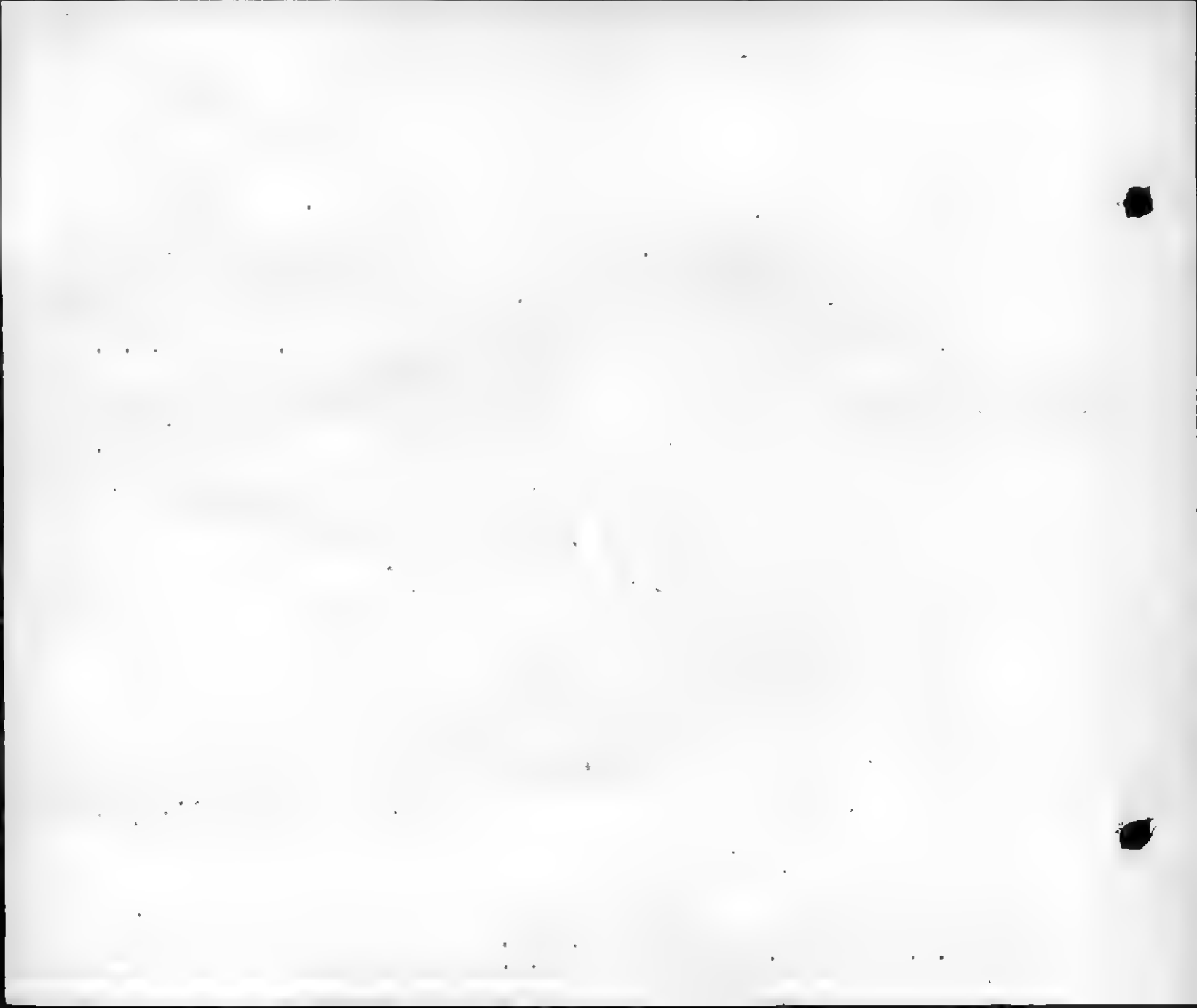


1  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 Items 8 & 9, Film G-2.3 12, 24, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

11505

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1108 Dryden St.</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 Silver Spring</b> d. STREET ADDRESS <b>1108 Dryden St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elizabeth M.</b> Middle <b>Browne</b> Last 4. DATE OF DEATH <b>October 13, 1959</b> Month <b>October</b> Day <b>13</b> Year <b>1959</b>		5. SEX <b>female</b> 6. COLOR OR RACE <b>white</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>3/21/77 1887</b> 9. AGE (In years last birthday) <b>72 82</b> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b> 11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Wilson Miller</b> 14. MOTHER'S MAIDEN NAME <b>Mary Frances Darley</b> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <b>483-20-0694</b> INFORMANT <b>2008 Osborn Dr. Silver Spring, Md.</b> <b>Mary Gardner</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal bronchopneumonia</b> 260 X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost (b) <b>Cardiac vascular disease</b> DUE TO (c) <b>Diabetes mellitus</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <b>Apr 4, 1934</b> to <b>OCT 13, 1959</b> that I last saw the deceased alive on <b>OCT 12, 1959</b> and that death occurred at <b>5:00 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1822 Biltmore St NW Washington D.C.</b> DATE SIGNED ACTUAL SIGNATURE <b>E. E. Gwyle</b> PHYSICIAN'S NAME (Type) <b>E. E. Gwyle</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b> 22b. DATE THEREOF <b>10/15/59</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Congressional Cemetery</b> 22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b> <b>2901 14th St. N.W. Washington 9, D.C.</b> 24a. REC'D BY REGISTRAR <b>OCT 15 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11506

11559

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institut an Residence before admiss on) a. STATE <b>Virginia</b> b. COUNTY <b>McLean</b>	
c. LENGTH OF STAY IN Tb <b>17 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>McLean</b>		d. STREET ADDRESS <b>5403 Youngblood Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Virginia Bean BRYAN</b>		4. DATE OF DEATH Month Day Year <b>October 9 19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-4-07</b>	9. AGE (In years last birthday) <b>52</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Watts BEAN</b>		14. MOTHER'S MAIDEN NAME <b>Lu KIDWELL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>(Husband) Louis A Bryan Same as #2</b>		INFORMANT Address <b>(Husband) Louis A Bryan Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of Pancreas</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>(City or town) (County) (State)</b>	
21. I certify that I attended the deceased from <b>22 Sept. 1959</b> to <b>9 October 1959</b> that I last saw the deceased alive on <b>9 October 19 59</b> , and that death occurred at <b>8:00 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda Md. 10-9-59</b> ACTUAL SIGNATURE <b>R. G. Muth</b> M.D. <b>U.S. Naval Hospital, Bethesda Md.</b> PHYSICIAN'S NAME (Type) <b>R.G. MUTH LT MC USN</b> <b>U.S. Naval Hospital, Bethesda Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-13-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	
22d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>A. C. Pumphrey</b>		24a. REC'D BY REGISTRAR <b>13 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		25. ADDRESS <b>7557 Sponsin Ave. Bethesda Md.</b>			

Handwritten text at the bottom right corner, possibly a signature or date, appearing to read "1901" followed by illegible characters.



11560

## CERTIFICATE OF DEATH

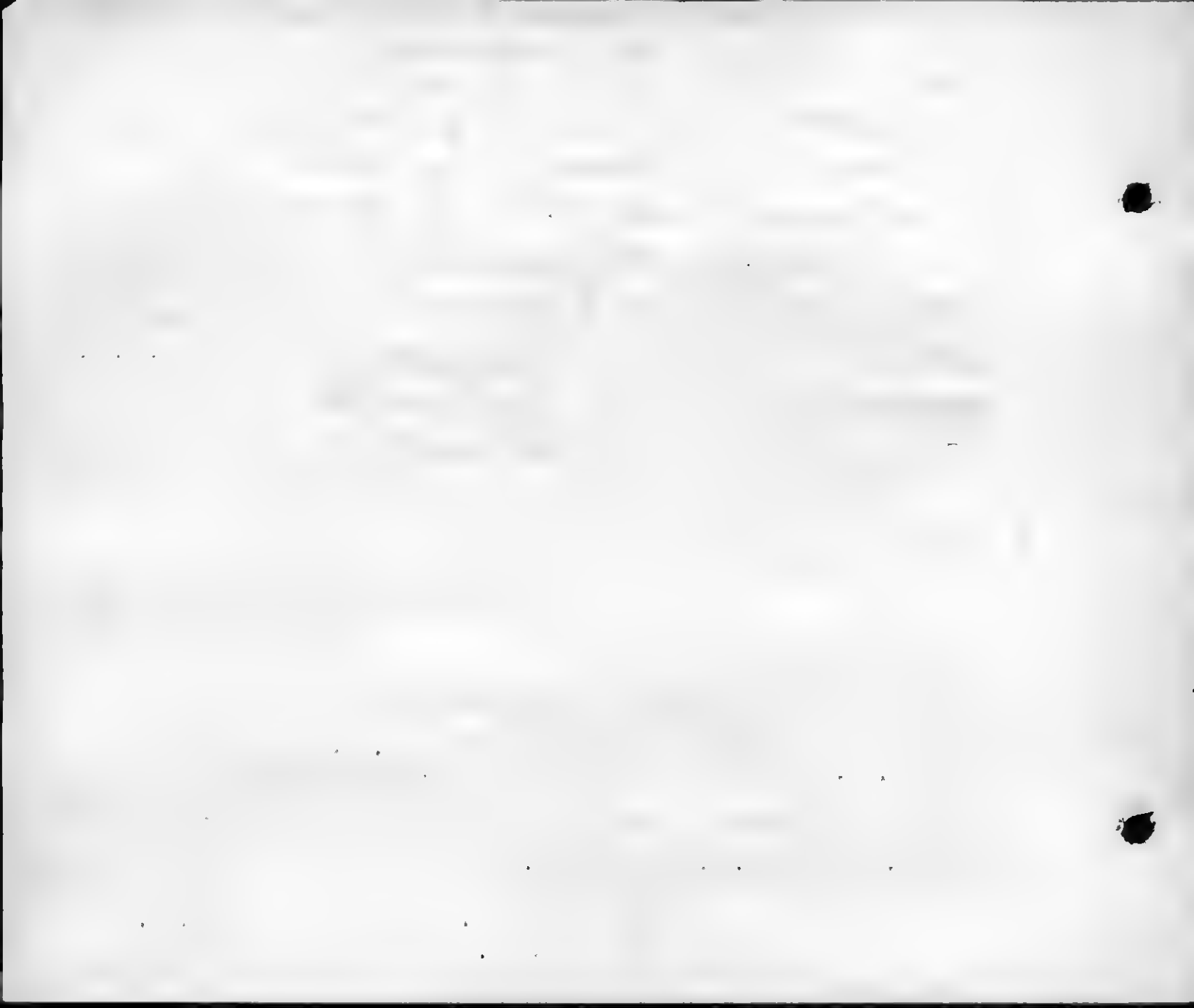
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>5 hours</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital, Inc.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Nettie Virginia Burdette</b>		4. DATE OF DEATH Month Day Year <b>October 5 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8.31.1881</b>
9. AGE (In years last birthday) <b>78 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>George Brown</b>		14. MOTHER'S MAIDEN NAME <b>Jennie Young</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>--</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Leukemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>January 19 41</b> to <b>Oct. 5, 19 59</b> , that I last saw the deceased alive on <b>Oct. 4, 19 59</b> , and that death occurred at <b>1:08 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>M. M. Boyer, M. D.</b>		ADDRESS (Street, city or town, state) <b>Druid Theatre Building, 10/5/59</b>	
PHYSICIAN'S NAME (Type) <b>M. M. Boyer, M. D., Damascus, Md.</b>		DATE SIGNED <b>10.5.59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/7/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Montgomery Meth.</b>		22d. LOCATION (City, town, or county) (State) <b>Clagetsville, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Olin L. Mohrmanth</b>		24a. REC'D BY REGISTRAR <b>DATE OCT 7 '59</b>	
ADDRESS <b>Damascus, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur A. Kline</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11508

11561

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>	
c. LENGTH OF STAY IN lb <b>33 years</b>		d. STREET ADDRESS <b>4136 Leland Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4136 Leland St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>PEARL Mary BURDINE</b>		4. DATE OF DEATH <b>Oct. 10, 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 23, 1875</b>
9. AGE (In years last birthday) <b>84</b>		10. IF UNDER 1 YEAR <b>7</b> Months <b>17</b> Days <b>19</b> Hours <b>59</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk - Govt.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William T. Burdine</b>		14. MOTHER'S MAIDEN NAME <b>Susan Wagner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Adelia J. Downey - Sister - Item #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> DUE TO (b) <b>Cerebrovascular Accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause ast. (c) <b>Arteriosclerosis</b> DUE TO (c) <b>Arteriosclerosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 9, 1959</b> to <b>Oct 10, 1959</b> that I last saw the deceased alive on <b>Oct 9, 1959</b> , and that death occurred at <b>10 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>8106 Maple Ridge Rd Bethesda, Md</b>			
ACTUAL SIGNATURE <b>William T. Joyce, M. D.</b>		M.D. <b>8106 Maple Ridge Rd Bethesda, Md</b>	
PHYSICIAN'S NAME (Type) <b>William T. Joyce, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-13-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Humphrey</b>		24a. REC'D BY REGISTRAR <b>OCT 14 '59</b>	
ADDRESS <b>Bethesda, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

[illegible]

10/10/10

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

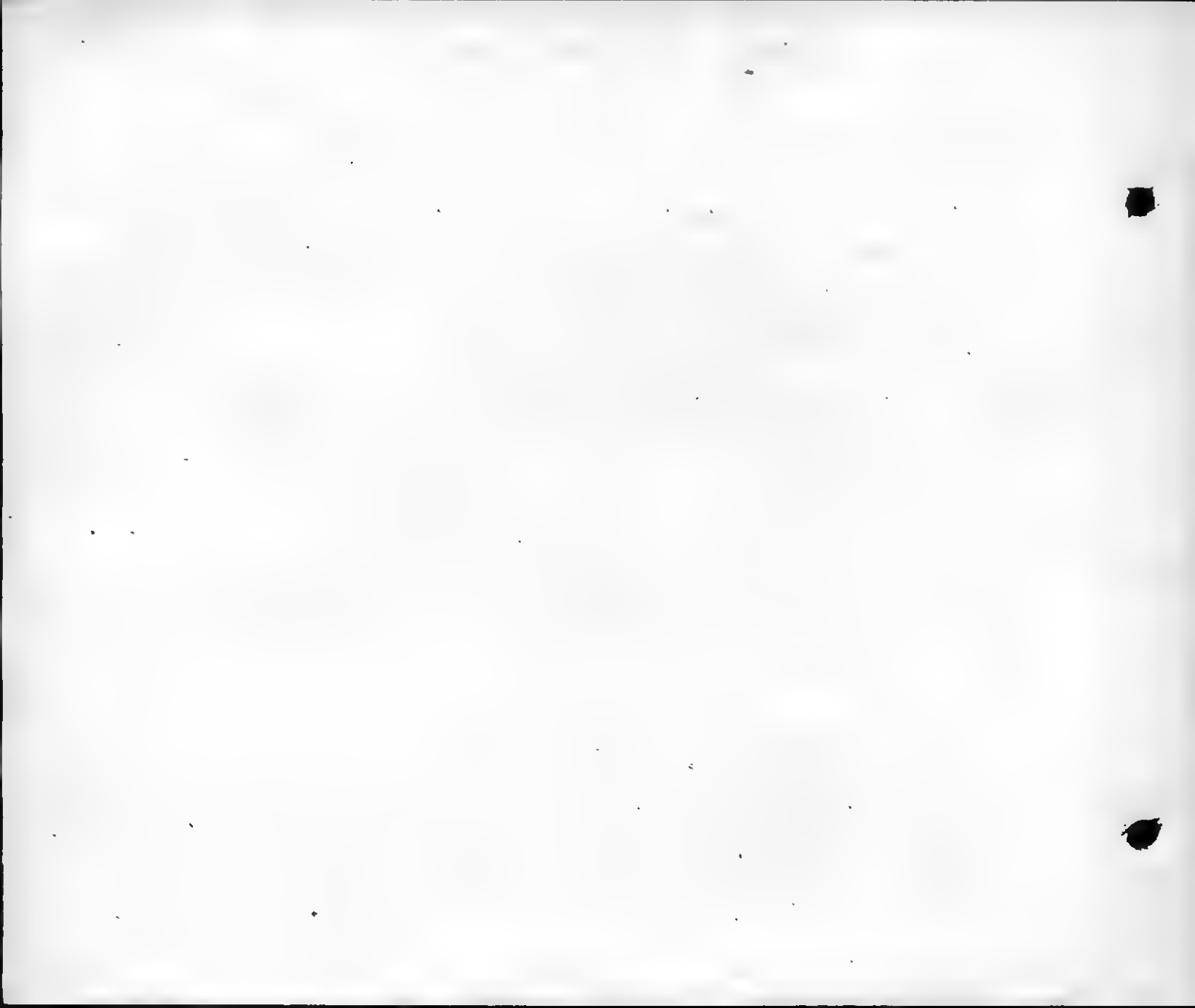
VS A15 (4)  
15M 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11504 CERTIFICATE OF DEATH

11509

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institut on. Residence before admision) a. STATE <i>D.C.</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington 47</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sen + Hospital</i>		d. STREET ADDRESS <i>Apt 204, 4912 New Hampshire Ave NW</i>	
3. NAME OF DECEASED (Type or print) <i>Edna (NAN) Buxack</i>		4. DATE OF DEATH <i>10-27</i> 19 <i>59</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-26-81</i>
9. AGE (In years last birthday) <i>78</i> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>High School teacher</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Miss.</i>		12. CITIZEN OF WHAT COUNTRY? <i>American</i>	
13. FATHER'S NAME <i>Unknown to pt (Buxack)</i>		14. MOTHER'S MAIDEN NAME <i>Anna (unknown)</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> 4 <i>CU Accident</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Arteriosclerosis</i> DUE TO (b) <i>Arteriosclerosis</i> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <i>18 hours</i> <i>18 hours</i> <i>years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Oct 25, 1959</i> to <i>Oct 27, 1959</i> , that I last saw the deceased alive on <i>Oct 27, 1959</i> , and that death occurred at <i>7:27 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Robert A. Hare</i>		ADDRESS (Street, city or town, state) <i>M.D. 7600 Carroll Ave, Takoma Park, Md. 20912</i>	
PHYSICIAN'S NAME (Type) <i>Robert A. Hare</i>		DATE SIGNED	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>11-2-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Greenwood</i>		22d. LOCATION (City, town, or county) (State) <i>Jackson Miss.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>DEAL FUNERAL HOME</i>		ADDRESS <i>4812 Ga Ave DC.</i>	
24a. RECEIVED BY REGISTRAR DATE <i>NOV 2 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	



11562 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**CERTIFICATE OF DEATH**

11510

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>10 da</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>Edna Pearl Bushong</u>				4. DATE OF DEATH Month Day Year <u>10 23 1959</u>			
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>10/17/93</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gov't. Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Samuel DW Everett</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jane Persing</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Harry J. Bronck</u>		INFORMANT Address <u>Silver Sp. Md. Luzerne Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> 465X DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <u>Status Postoperative - Resection Transverse Colon</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <u>9 Oct</u> , 19 <u>59</u> , to <u>23 Oct</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>22 Oct</u> , 19 <u>59</u> , and that death occurred at <u>745</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Edward C. Wilson Jr.</u> M.D. <u>1801 Eye St. N.W. Wash DC</u> <u>23 Oct 59</u> PHYSICIAN'S NAME (Type) <u>Edward C. Wilson, Jr.</u> 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>10/26/59</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u> 22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u> 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>S. H. Hines Co 2901-14 St. N.W.</u> 24a. REC'D BY REGISTRAR DATE <u>OCT 26 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>							

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





CERTIFICATE OF DEATH

11511

Reg. Dist. No.

11563

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Died at home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ELSPET</b> Middle <b>GAREN</b> Last <b>BUTLER</b>				4. DATE OF DEATH Month <b>OCT</b> Day <b>19</b> Year <b>1959</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-5-1914</b>	9. AGE (In years last birthday) <b>45</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SECRETARY</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Woodard Dept</b>		11. BIRTHPLACE (State or foreign country) <b>COLONGE, GERMANY</b>		12. CITIZEN OF WHAT COUNTRY? <b>British</b>	
13. FATHER'S NAME <b>William JACKSON</b>				14. MOTHER'S MAIDEN NAME <b>ELSPET GAREN PIRIE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO <b>577-01-6290</b>		INFORMANT <b>ELSPET GAREN PIRIE</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of colon with metastases</b> 103.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 15, 1959</b> to <b>Oct 14, 1959</b> , that I last saw the deceased alive on <b>Oct 14, 1959</b> and that death occurred at <b>7 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>9500 Coleville Rd Silver Spring, Md.</b> DATE SIGNED							
ACTUAL SIGNATURE <b>H. B. ORLEANS</b> M.D.				DATE SIGNED <b>OCT 20 '59</b>			
PHYSICIAN'S NAME (Type) <b>H. B. ORLEANS</b>				DATE SIGNED <b>OCT 20 '59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 17, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MONTGOMERY</b>		22d. LOCATION (City, town, or county) (State) <b>BEALLSVILLE, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Constance C Helton Barnesville, Md.</b>				24a. REC'D BY REGISTRAR <b>OCT 20 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Orlana S. Frank</b>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CHARLES M. BUTLER -  
ALPHA I. BUTLER NOTES

FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

WS. A11ME  
SM 2/57

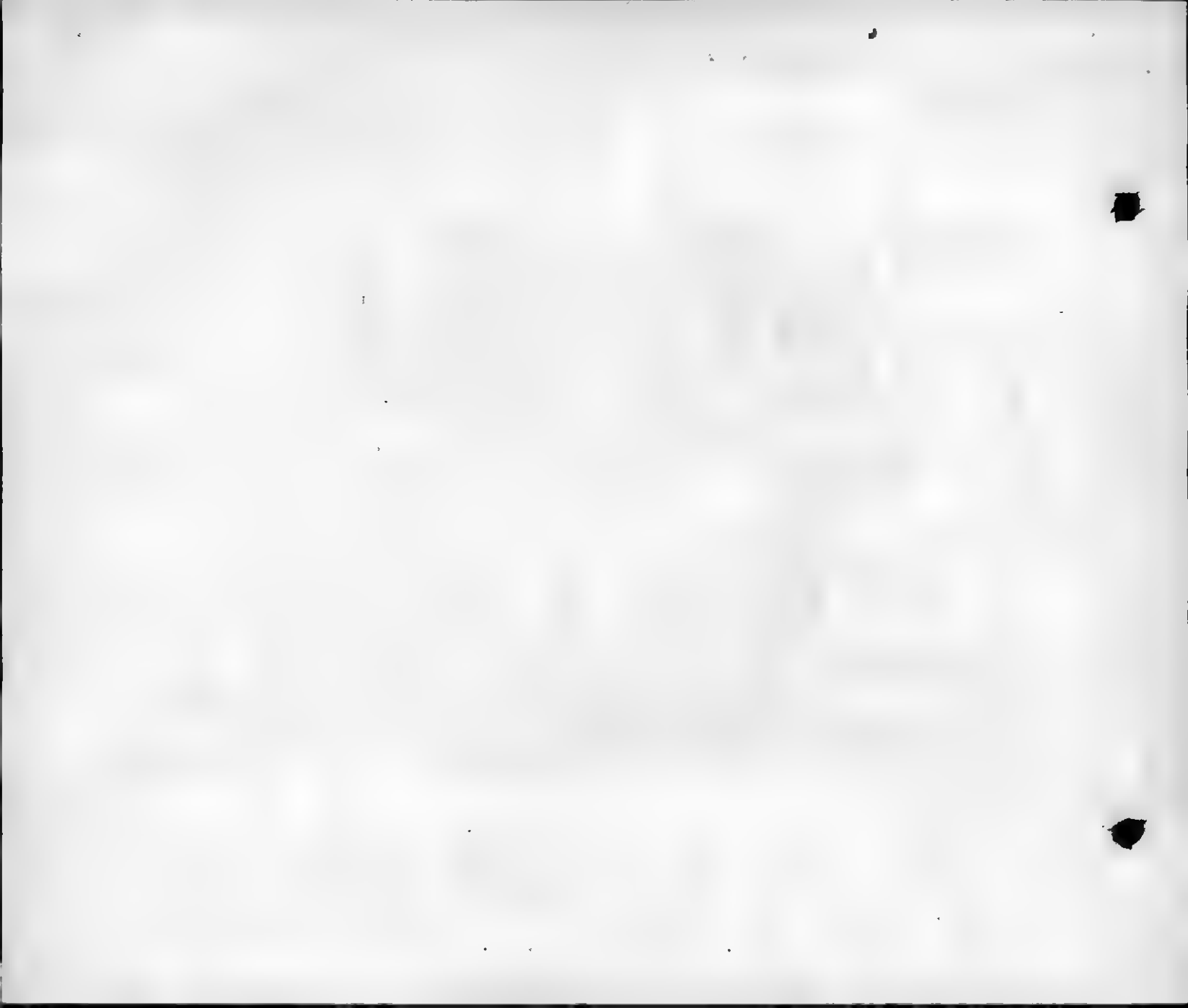
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11564 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11512

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Woodmoor Bowling Alley</b>			e. STREET ADDRESS <b>416 Whitestone Rd</b>		
3. NAME OF DECEASED (Type or print) <b>George H Came</b>			4. DATE OF DEATH <b>Oct. 14, 1959</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 19, 1899</b>		9. AGE (In years last birthday) <b>60</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Gov. Retired</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>INFORMATION RECEPTIONIST</b>		11. BIRTHPLACE (State or foreign country) <b>New Hampshire</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Jairus</b>		
14. MOTHER'S MAIDEN NAME <b>Etta Hobbs</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		
16. SOCIAL SECURITY NO. <b>none</b>			17. INFORMANT <b>Frieda</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>2.1</b> (c), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Frank J. Brosch</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>J. Brosch</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)		
<b>TRANS. &amp; BURIAL</b>	<b>10/16/59</b>	<b>Forest Glade Cemetery</b>	<b>Somersworth, New Hampshire</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Ziska</b>		ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR <b>OCT 16 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraw</b>



11565

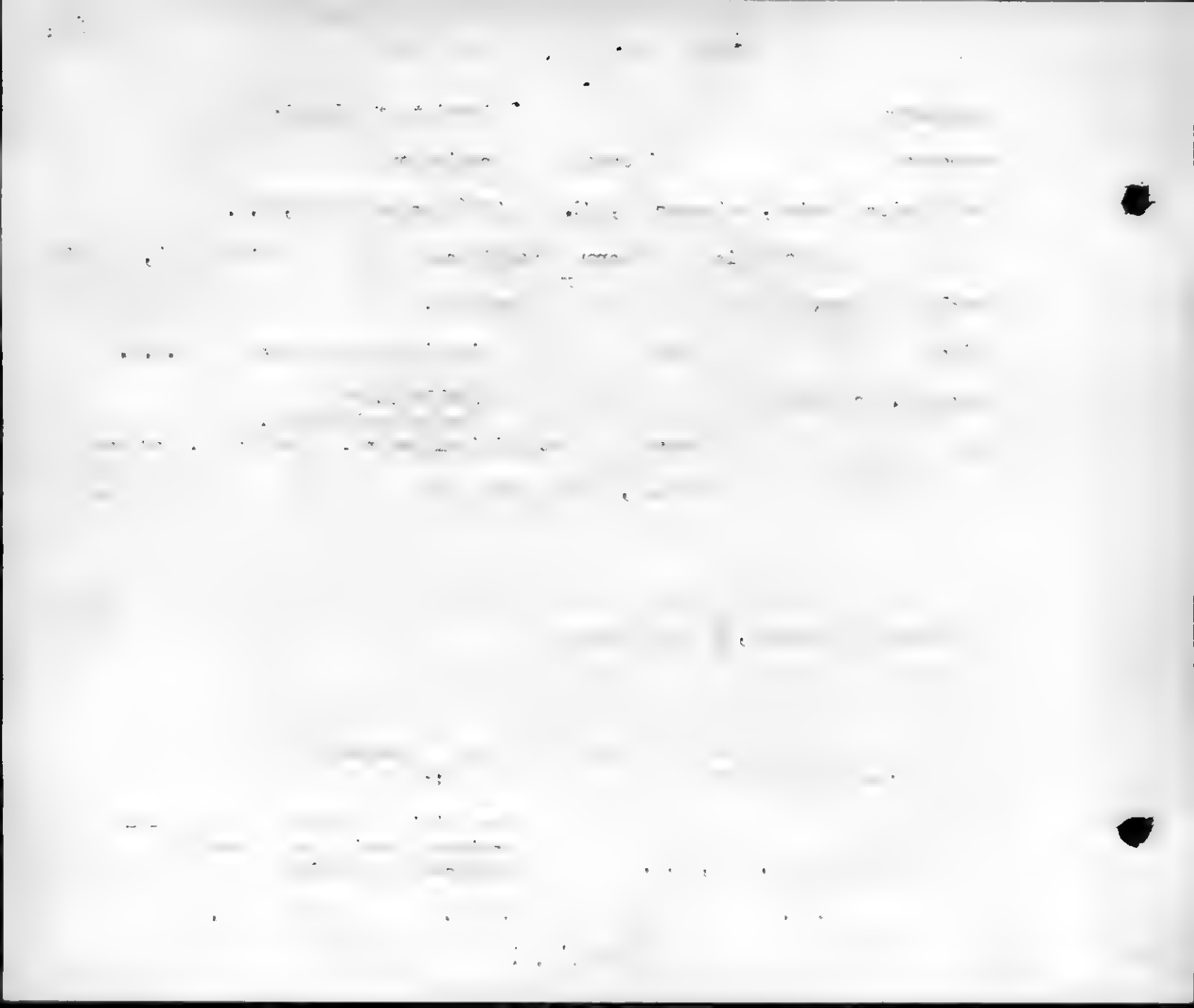
## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>87 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2 USUAL RESIDENCE (Where deceased lived If instit' on Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>District of Columbia</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>2206 Flagler Place, N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Patricia Sharon Carmichael</b>		4. DATE OF DEATH Month Day Year <b>October 8, 1959</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 31, 1959</b>
9. AGE (In years last birthday) <b>6</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min. <b>6 8</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Roland S. Carmichael</b>		14. MOTHER'S MAIDEN NAME <b>Isabelle Payne</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
INFORMANT <b>The Medical Record,</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, Right upper Lobe</b> 475 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Epidural Hematoma, Right Parietal</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 13, 1959</b> to <b>October 8, 1959</b> , that I last saw the deceased alive on <b>October 8, 1959</b> , and that death occurred at <b>1:20 PM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>William S. Sly, M.D.</b>		M.D. <b>The Clinical Center</b> <b>10-8-59</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>WILLIAM S. SLY, M.D.</b>			
22a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10.13.59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l. Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert J. McQuire</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 13 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Orlino E. Kramer</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										11514							
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.							
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>140 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center</b>					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Mississippi</b> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Meridian</b> d. STREET ADDRESS <b>Route # 6, Box 33</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
3. NAME OF DECEASED (Type or print) First <b>Raymond</b> Middle <b>(None)</b> Last <b>Chappell</b>					4. DATE OF DEATH Month <b>October</b> Day <b>29</b> Year <b>1959</b>												
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 9, 1940</b>		9. AGE (in years last birthday) <b>19</b> yrs.		10. IF UNDER 1 YEAR Months <b>13</b> Days <b>13</b>		11. IF UNDER 24 HRS. Hours <b>13</b> Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>				11. BIRTHPLACE (State or foreign country) <b>Mississippi</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>Willie Chappell</b>						14. MOTHER'S MAIDEN NAME <b>Mattie L. Young</b>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>425-72-1213</b>				17. INFORMANT The Medical Record address <b>The Clinical Center, Bethesda 14, Maryland</b>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Acute Respiratory failure</b> DUE TO <b>955X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Some mechanical failure of Respirator</b> (c) <b>Polyneuropathy</b>										INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>Months</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute broncho-pneumonia</b>																	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Mechanical failure of Respirator</b>													
20c. TIME OF INJURY Month, Day, Year <b>3:15 P.M. 10-29-59</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N.L.H. Hosp</b>		20f. (City or town) <b>Bethesda</b>		(County) <b>Montg.</b>		(State) <b>Md.</b>					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																	
ACTUAL SIGNATURE <b>Frank S. Broschart</b> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <b>10-29-59</b>							
EXAMINER'S NAME (Type) <b>FRANK S. BROSCART, M.D.</b>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>10-31-59</b>				22b. DATE THEREOF				22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or county) <b>Meridian</b> (State) <b>Miss</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fraxers Funeral Home</b>						ADDRESS				24a. REC'D BY REGISTRAR DATE <b>NOV 2 '59</b>				24b. REGISTRAR'S SIGNATURE <b>C. H. S. Hines</b>			





1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11567

CERTIFICATE OF DEATH

11515

Reg. Dist No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b <b>35 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1907 GRACE CHURCH ROAD</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
f. STREET ADDRESS <b>1907 GRACE CHURCH ROAD</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LESLIE</b> Middle <b>MERLE</b> Last <b>CHRISTIE</b>		4. DATE OF DEATH Month <b>OCT.</b> Day <b>26</b> Year <b>19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/25/81</b>
9. AGE (In years lost birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>10</b> Hours <b>59</b> Min	11. IF UNDER 24 HRS Months <b>6</b> Days <b>10</b> Hours <b>59</b> Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Orthodontist (retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PENNSYLVANIA</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MILTON H. CHRISTIE</b>		14. MOTHER'S MAIDEN NAME <b>JOSEPHINE H. RHODES</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b>	
17. ADDRESS <b>Mrs. Elvene C. Christie, 1907 Grace Church Rd.</b>		18. ADDRESS <b>Silver Spring, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Failure</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Myocardial Degeneration</b> DUE TO (c) <b>Myocardial infarction</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>6 days</b> <b>3 yrs</b> <b>5 yrs</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 1954</b> to <b>10/26 1959</b> , that I last saw the deceased alive on <b>10/25 1959</b> , and that death occurred at <b>7:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Merrill M. Cross MD</b>		ADDRESS (Street, city or town, state) <b>M.D. 8248 Georgia Ave.</b>	
PHYSICIAN'S NAME (Type) <b>MERRILL M. CROSS MD</b>		DATE SIGNED <b>10/26/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		22b. DATE THEREOF <b>10/29/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CREMATORY</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b>		24a. REC'D BY REGISTRAR <b>Raymond A. Ziska</b>	
ADDRESS <b>SILVER SPRING, MD.</b>		24b. REGISTRAR'S SIGNATURE <b>OCT 28 '59</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
11568  
CERTIFICATE OF DEATH

Reg. Dist. No. 11516

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b> c. LENGTH OF STAY IN 1b <b>3 DAYS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY COUNTY GENERAL HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HOWARD</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HIGHLAND</b> d. STREET ADDRESS <b>138</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHRISTOPHER CLAUDE CISSEL</b>		4. DATE OF DEATH Month Day Year <b>OCTOBER 20 19 59</b>	
5. SEX <b>MALE</b> <b>XXXX</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/23/80</b>
9. AGE (In years lost birthday) <b>79</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>PHILLIP CISSEL</b>		14. MOTHER'S MAIDEN NAME <b>ELLEN MARTHA ZEIGLER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>218-36-1088</b>	
17. INFORMANT <b>HOSPITAL RECORDS</b>		Address <b>OLNEY, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b> DUE TO (b) <b>Phlebotrombosis (Saphenous)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Pulmonary infarction</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of prostate</b> INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July</b> , 19 <b>46</b> , to <b>Oct 20</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Oct 20</b> , 19 <b>59</b> , and that death occurred at <b>4:05 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Charles S. Whitaker</b>		M.D.	
PHYSICIAN'S NAME (Type) <b>C. S. WHITAKER, M. D.</b>		<b>CLARKSVILLE, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-23-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion</b>	22d. LOCATION (City, town or county) (State) <b>Highland Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higginbotham, Ellicott City, Md</b>		24a. REC'D BY REGISTRAR <b>OCT 26 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thane</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

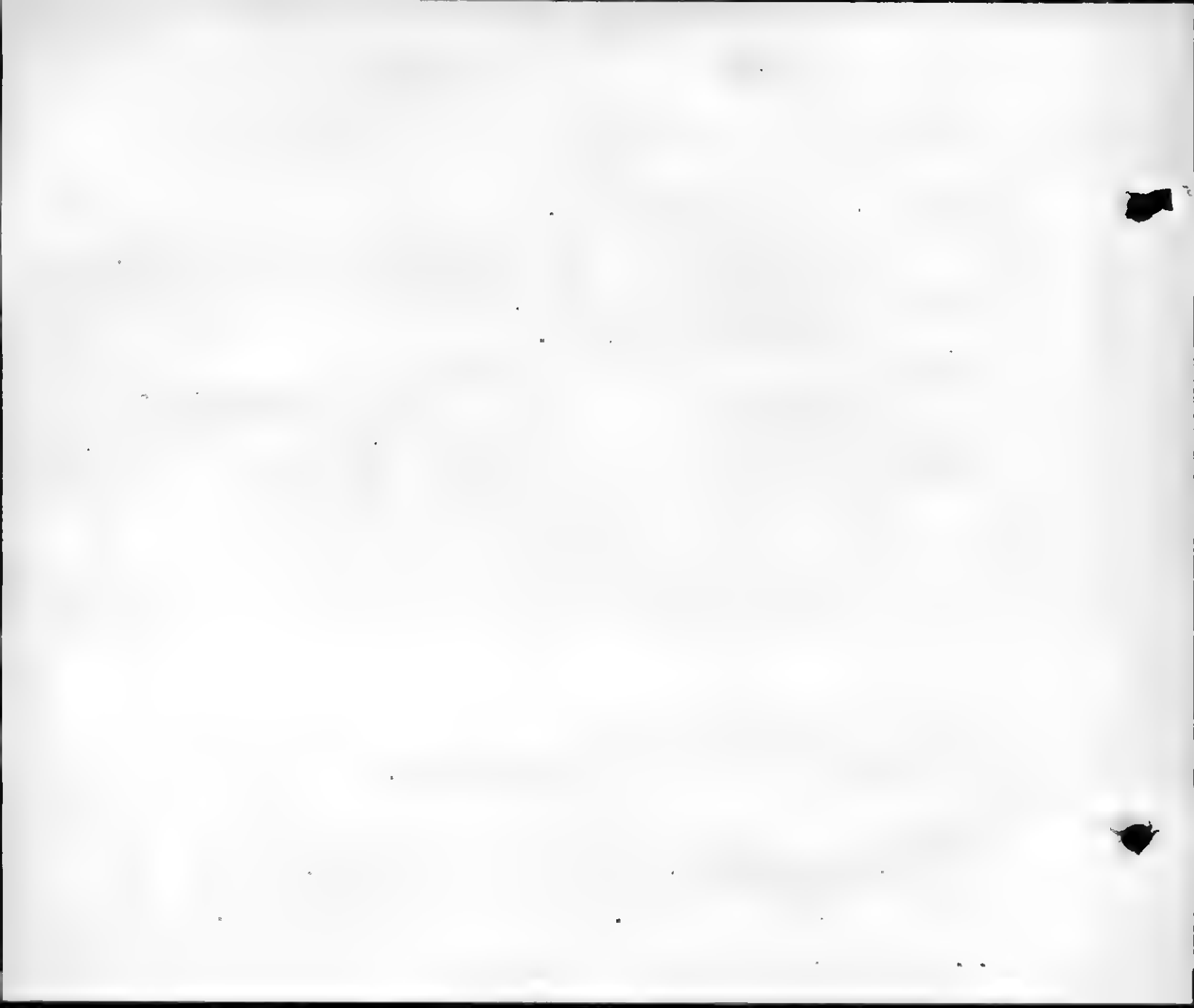
11517

11569

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>				c. LENGTH OF STAY IN 1b <b>8 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital, Inc.</b>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <b>Edith</b> Middle <b>Clarke</b> Last <b>Clarke</b>				4. DATE OF DEATH Month <b>October</b> Day <b>29</b> Year <b>19 59</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2.10.1883</b>		9. AGE (In years last birthday) <b>76</b> yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Electrical Engr. Professor</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Ridgley Clarke</b>				14. MOTHER'S MAIDEN NAME <b>Susan Dorsey <del>OWENS</del> Owings</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>?</b>		INFORMANT <b>Hospital Records</b> <b>Olney, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Uremia due to nephrosclerosis</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July</b> , 19 <b>57</b> , to <b>Oct 29</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Oct 28</b> , 19 <b>59</b> , and that death occurred at <b>8:10 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <b>Charles S. Whitaker, M.D.</b>				PHYSICIAN'S NAME (Type) <b>C. S. Whitaker, M.D.</b> <b>Clarksville, Maryland</b>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-31-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Johns</b>		22d. LOCATION (City, town, or county) (State) <b>Ellicott City, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md</b>				24a. REC'D BY REGISTRAR <b>NOV 2 '59</b>		24b. REGISTRAR'S SIGNATURE <b>C. S. Whitaker</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

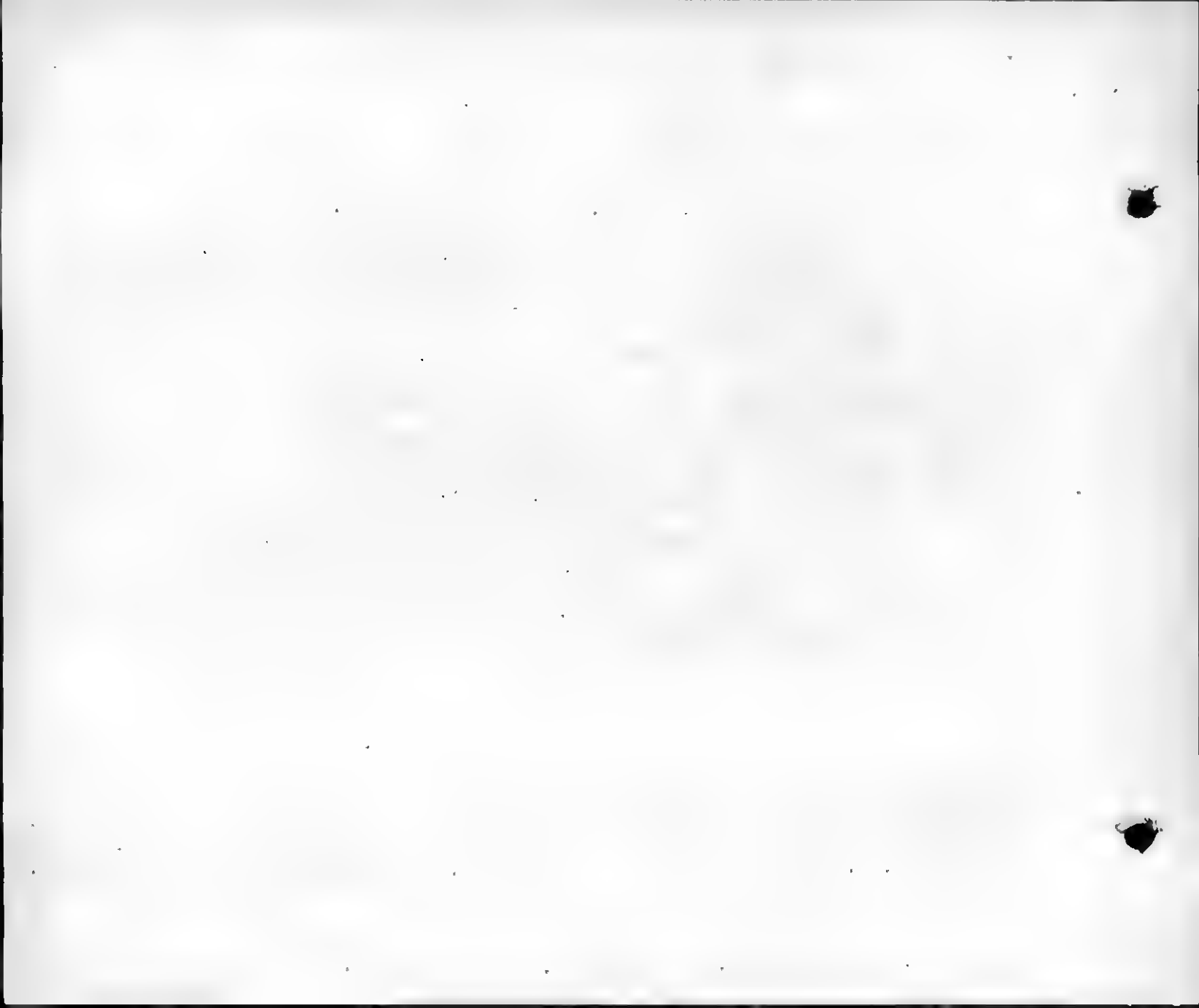
11570

CERTIFICATE OF DEATH

Reg. Dist. No.

11518

1 PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, Bethesda, Md.		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Virginia		b. COUNTY X	
3 NAME OF DECEASED (Type or print) First Middle Last Grace Emmons CLIFFORD		4. DATE OF DEATH Month Day Year October 21 1959		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5 SEX Female	6 COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-15-82	9. AGE (In years last birthday) 77 yrs	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Michigan		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME Melrey Emmons		14. MOTHER'S MAIDEN NAME Augusta Dimler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		INFORMANT Hospital Records	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]. PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease (c)					INTERVAL BETWEEN ONSET AND DEATH 24 hrs
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 20 October, 1959 to 21 October, 1959, that I last saw the deceased alive on 21 October, 1959, and that death occurred at 6:45 A. M., from the causes and on the date stated above.					
ACTUAL SIGNATURE P. S. Muth		ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNMC, Bethesda, Md.			
DATE SIGNED 10-21-59					
PHYSICIAN'S NAME (Type) R. G. MUTH LT MC USN		U. S. Naval Hospital, NNMC, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Cremation 10/23/59, Green Burial		22b. DATE THEREOF 10/23/59		22c. NAME OF CEMETERY OR CREMATORY Detroit Michigan	
23 FUNERAL DIRECTOR'S SIGNATURE Demaine Funeral Home		ADDRESS S. Washington St., Alexandria, Va.		24a. REC'D BY REGISTRAR OCT 23 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Evans	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

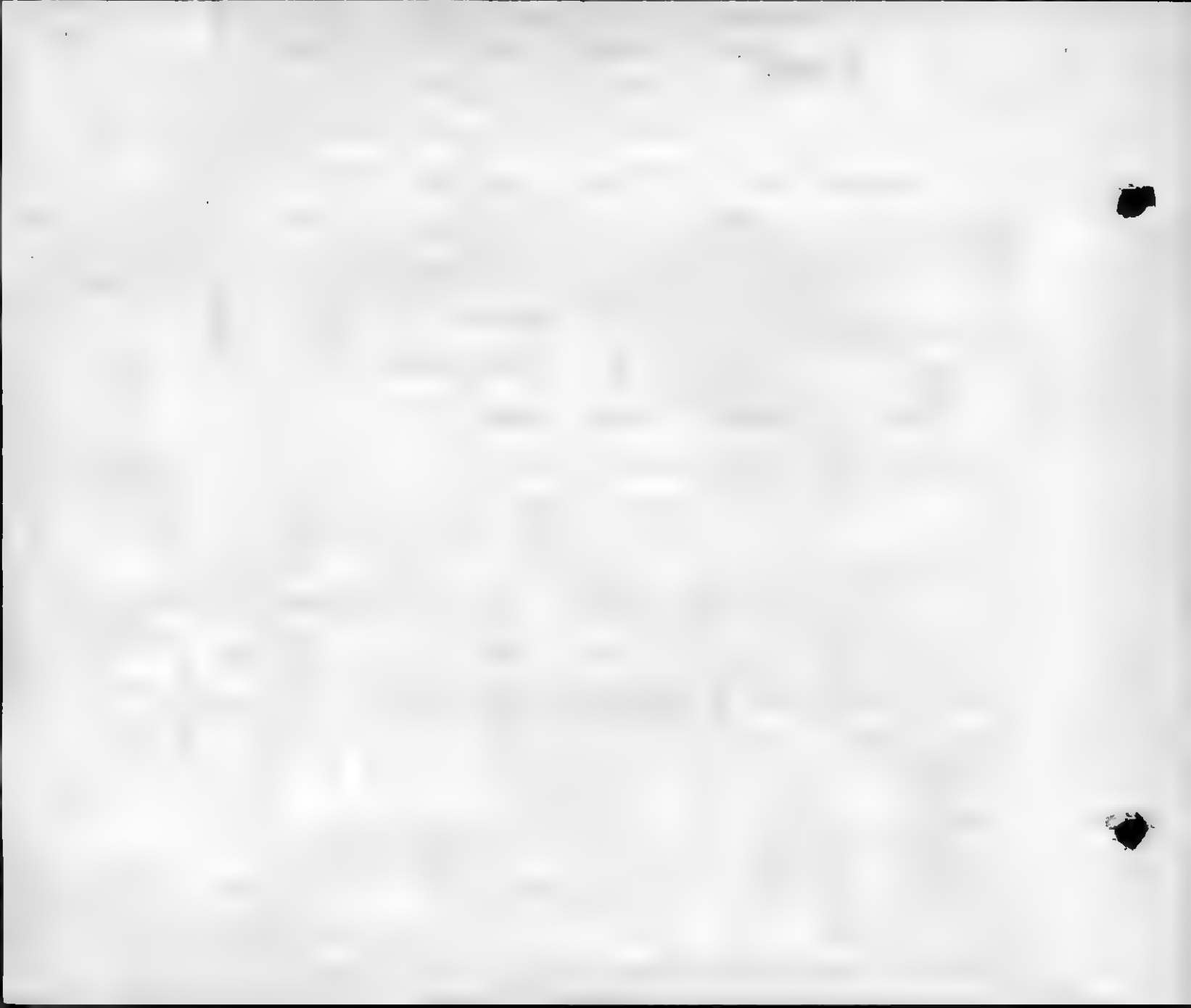
11519

Reg. Dist. No.

11505

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN TB <u>25 min</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENNESAW</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SANITARIUM + Hosp.</u>				1. d. STREET ADDRESS <u>3509 PERRY AVE.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ISABELL</u> Last <u>COTTRELL</u>				4. DATE OF DEATH Month <u>10</u> Day <u>18</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>Wh</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-2-9-06</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>3</u> Hours <u>15</u> Min.		IF UNDER 24 HRS. Hours <u>15</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Belfast - IRELAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>IRELAND</u>	
13. FATHER'S NAME <u>James Caldwell</u>				14. MOTHER'S MAIDEN NAME <u>Jane Mary Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>Charles Cottrell</u>		Address <u>4201 New Hamp. HATT. RD AVE.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 4 2.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>                    </u> DUE TO (c) <u>                    </u>							INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>                    </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>                    </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>10-18-59</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 21, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>First Kinship Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges County Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kincaid</u>				ADDRESS <u>254 Carroll St. N. Wash DC</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 21 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kincaid</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Page 1, 2, and 3 to the funeral director. Give Page 4 to the funeral home. The Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



## CERTIFICATE OF DEATH

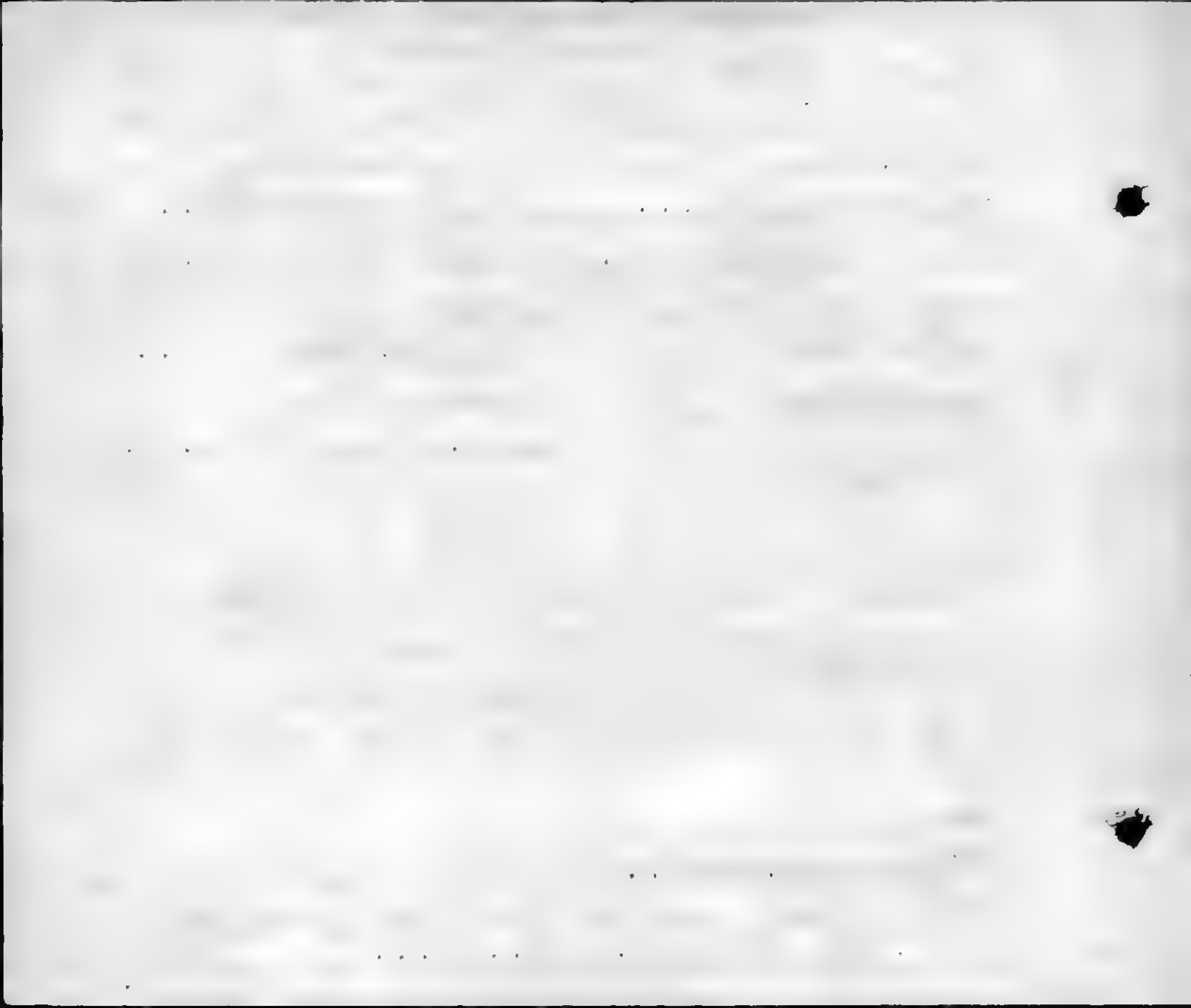
Reg. Dist. No.

11571

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WOOD ACRES, MARYLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WOOD ACRES, MARYLAND</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6007- MASSACHUSETTS AVENUE, N.W.</b>		d. STREET ADDRESS <b>6007- MASSACHUSETTS AVENUE, N.W.</b>	
3. NAME OF DECEASED (Type or print) First <b>LELLIAN</b> Middle <b>N.</b> Last <b>DALY</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>31</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/27/1881</b>
9. AGE (In years last birthday) <b>78</b> yrs		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>4</b> Hours <b></b> Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE - AT HOME</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE - AT HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>NOKEVILLE, VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SPOTWOOD SPINDLE</b>		14. MOTHER'S MAIDEN NAME <b>MARY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>EDWARD A. DALY (SON)</b>		Address <b>6007 MASS. AVE, WOOD ACRES</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>uremia</b> DUE TO <b>congestive heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>hypertensive heart disease</b> (c) <b>diabetic mellitus</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>diabetic mellitus</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b> <b>4 mo.</b> <b>10 yrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>9:50</b> p. m. Month, Day, Year <b>10 31 1959</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>April</b> , 1959, to <b>Oct. 31</b> , 1959, that I last saw the deceased alive on <b>October 30</b> , 1959, and that death occurred at <b>9:50 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Elaine W. Murphy</b>		M.D. <b>4812 E. 10th St N.W.</b>	
PHYSICIAN'S NAME (Type) <b>ELAINE W. MURPHY, M.D.</b>		ADDRESS (Street, city or town, state) <b>Washington 16 D.C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>11/4/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>WASHINGTON NATIONAL CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>SUITLAND, MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>MARTIN W. HYSOING COMPANY</b>		24a. REC'D BY REGISTRAR <b>DATE</b>	
ADDRESS <b>1300- N. STREET, N.W. WASH. D.C.</b>		24b. REGISTRAR'S SIGNATURE <b>William S. Frank</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low require that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



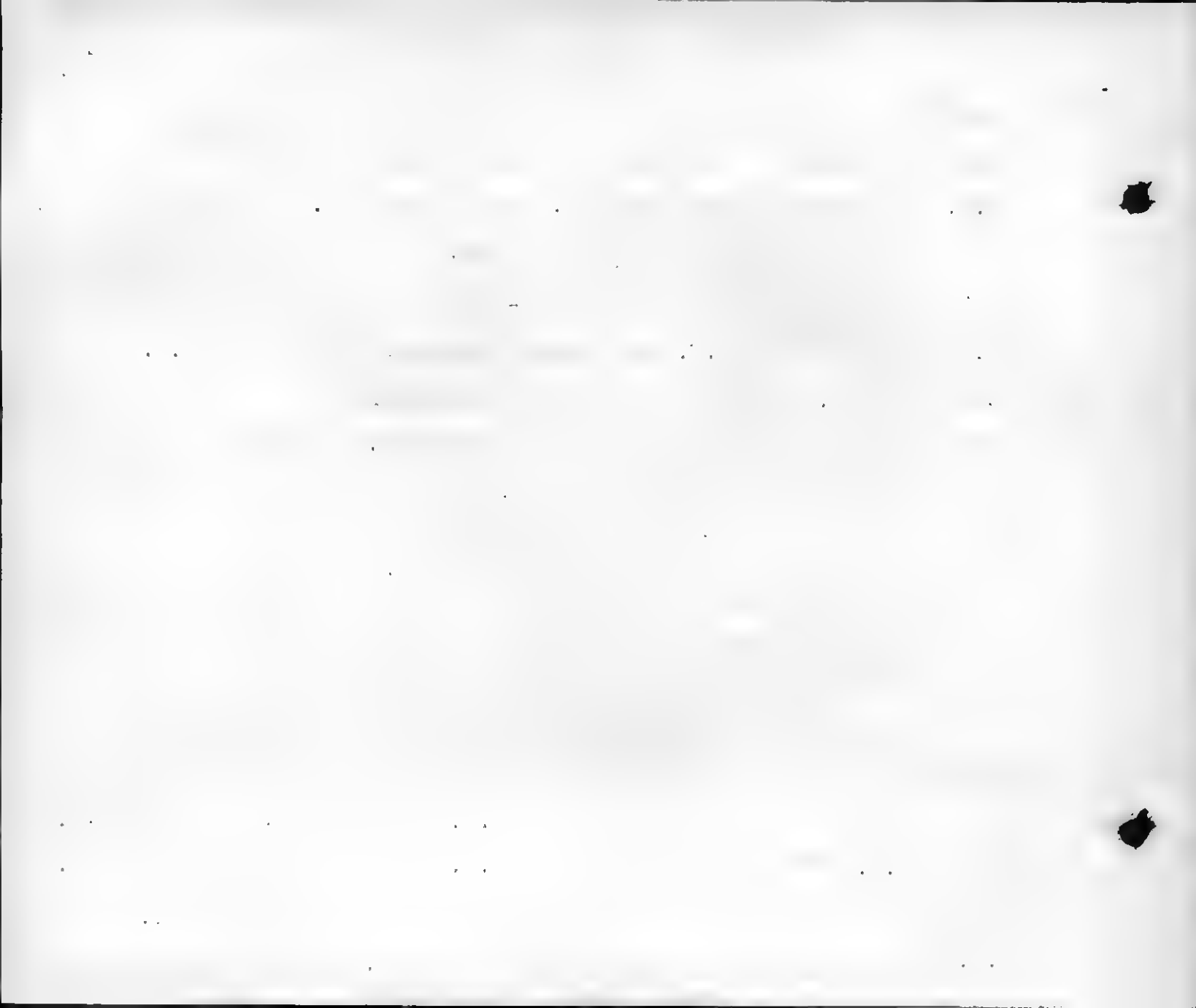
may be released by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11572 Item 22 Film G251 10-30-59 et CERTIFICATE OF DEATH

11521

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>1 day</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Chevy Chase</b> d. STREET ADDRESS <b>4911 Essex Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Freeland</b> Middle <b>Allyn</b> Last <b>DAUBIN</b>				4. DATE OF DEATH Month <b>October</b> Day <b>24</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-8-86</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS Hours _____ Min _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>		11. BIRTHPLACE (State or foreign country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Crittenden C. DAUBIN</b>				14. MOTHER'S MAIDEN NAME <b>Ella BOWEN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I &amp; II 547 46 6391</b>		INFORMANT <b>(Daughter) Mrs. Elizabeth Hartman</b>		Address <b>Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0 Congestive Heart Failure</b> DUE TO (b) <b>Arteriosclerosis generalized</b> and (c) <b>Hemorrhage secondary to gastric ulcer</b>						INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>10 years</b> <b>4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) _____					
20c. TIME OF INJURY Month _____ Day _____ Year _____ Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>23 October 1959</b> to <b>24 October 1959</b> that I last saw the deceased alive on <b>24 October 1959</b> , and that death occurred at <b>5:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <b>James M. Young</b>				M.D. <b>U.S. Naval Hospital, Bethesda, Md.</b>			
PHYSICIAN'S NAME (Type) <b>J.M. YOUNG LT MC USN</b>				<b>10-24-59</b> <b>U.S. Naval Hospital, Bethesda, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-25-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Rosecrans</b>		22d. LOCATION (City, town, or county) (State) <b>San Diego, Calif.</b>	
23. JUNE 1960 DIRECTOR'S SIGNATURE <b>R.A. Pumphrey</b>				ADDRESS <b>7557 Wisconsin Ave. Bethesda Md.</b>		24a. REC'D BY REGISTRAR <b>OCT 27 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			



## CERTIFICATE OF DEATH

Reg. Dist. No.

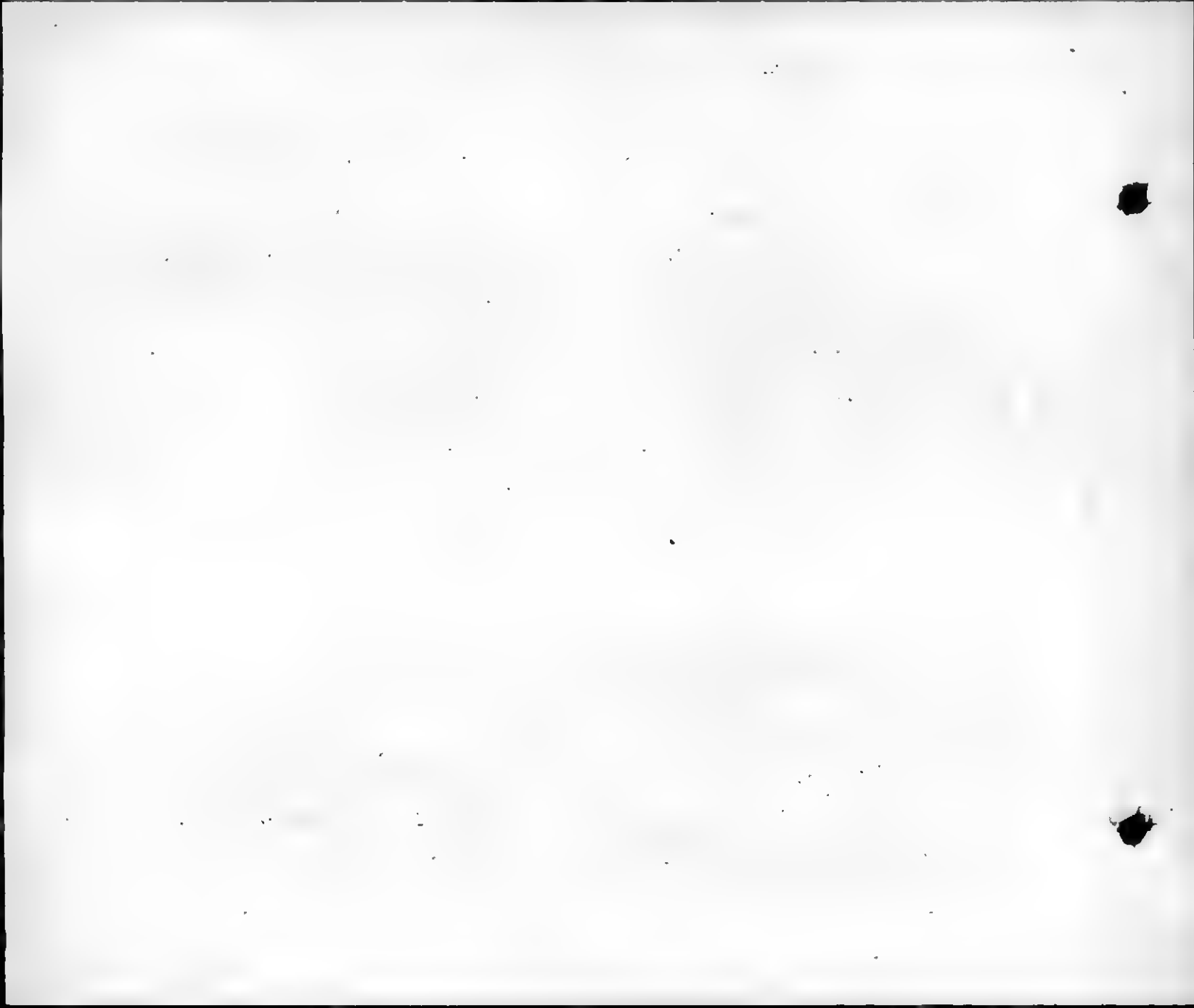
11522

11573

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Garrett Park</b>		c. LENGTH OF STAY IN lb <b>2 Months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>10930 Clermont Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>DALE</b> Middle <b>G.</b> Last <b>DAVIDSON</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>24,</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 6, 1894</b>
9. AGE (in years last birthday) yrs <b>64</b>		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>18</b>	11. IF UNDER 24 HRS. Hours <b>18</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Insurance agent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>	11. BIRTHPLACE (State or foreign country) <b>Ohio</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>William C. Davidson</b>	
14. MOTHER'S MAIDEN NAME <b>Mary P. Nath</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>	
16. SOCIAL SECURITY NO <b>275-03-7506</b>		INFORMANT <b>Wife</b> Address <b>Same as Item #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion -</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardio Vascular Disease Hypertension</b> DUE TO <b>10 yr.</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>24 Hr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>24 Oct</b> , 19 <b>59</b> , to <b>24 Oct</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>24 Oct</b> , 19 <b>59</b> , and that death occurred at <b>5:15 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John G. Ball</b>		DATE SIGNED <b>7936 Old Georgetown Rd., 10-25-59</b>	
PHYSICIAN'S NAME (Type) <b>JOHN G. BALL</b>		<b>Bethesda, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/28/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>OCT 30 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12697

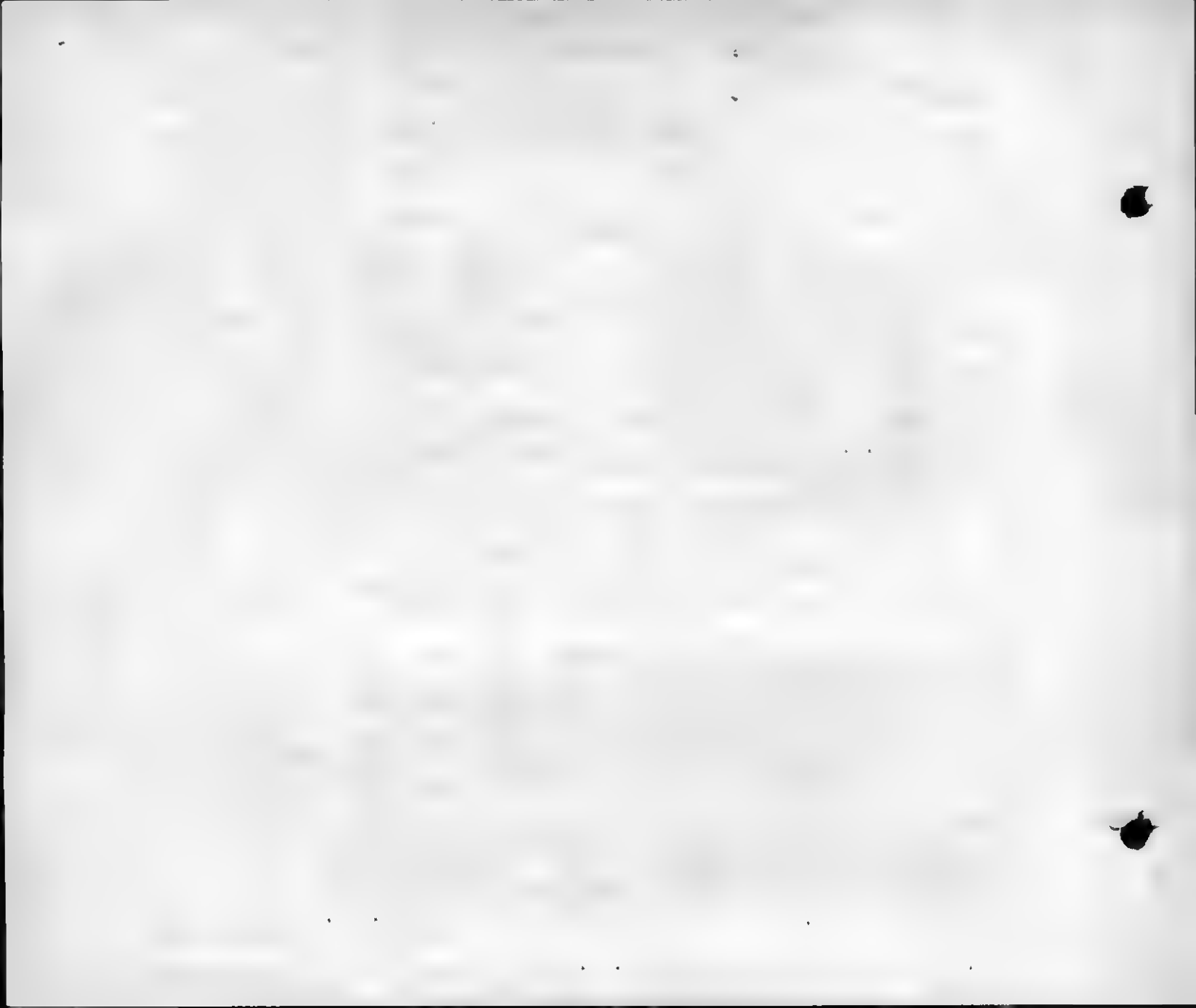
Reg. Dist. No.

11574

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>D.C.</u> <span style="float: right;">b. COUNTY</span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>235 Oakdale Place</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <span style="float: right;">First Middle Last</span> <u>Andrew Davis</u>				<b>4. DATE OF DEATH</b> Month <u>October</u> Day <u>1</u> Year <u>19 59</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>9/9/21</u>		9. AGE (In years last birthday) <u>38</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>			
13. FATHER'S NAME <u>Mose Davis</u>				14. MOTHER'S MAIDEN NAME <u>Sutton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>W.W.II</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT Address <u>Hospital records-Suburban Hospital</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;">           PART I. DEATH WAS CAUSED BY:            IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>            DUE TO            Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Thrombosis</u>            (a), stating the underlying cause last. DUE TO (c) _____         </div> <div style="width: 15%; text-align: center;">           INTERVAL BETWEEN ONSET AND DEATH   <u>Sudden</u> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Oct. 2, 1959</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>Oct. 5, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Shipped to: Levi Hamilton, Fun. Dir., Goldsboro, North Carolina</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Ernest Jarvis, Washington, D. C.</u>				24a. REC'D BY REGISTRAR <u>NOV 27 '59</u>			
ADDRESS 				24b. REGISTRAR'S SIGNATURE <u>Clifford S. Hines</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM3. Page 5 may be retained for your file.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.  
 11/17/59  
 VS. A15ME(5) mnbn  
 5M 9/55

REPLACEMENT CERTIFICATE\*ORIGINAL CLERK DATE 074 11/29/59-mab  
 AP. AREALITY SENT WITH THE BODY



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

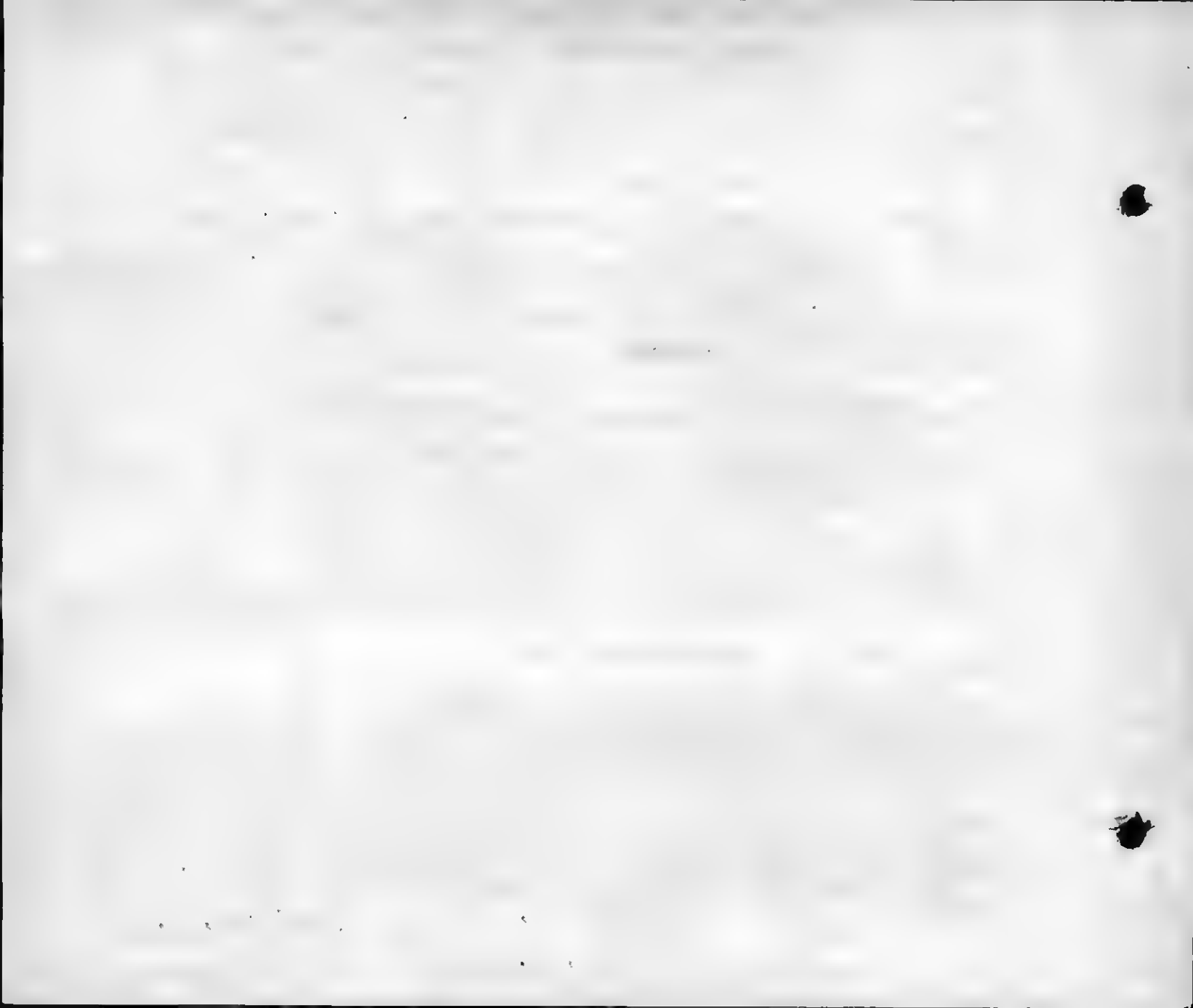
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11523

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>				c. LENGTH OF STAY IN 1b <b>1 day</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>10001 Georgia Ave.</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>			
3. NAME OF DECEASED (Type or print) First <b>Ghunward</b> Middle <b>Patterson</b> Last <b>Davis</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>20,</b> Year <b>1959</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>col.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 31, 1886</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months <b>73</b> Days <b>73</b> Hours <b>73</b> Min. <b>73</b>		IF UNDER 24 HRS. Hours <b>73</b> Min. <b>73</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>G. Monner</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Benjamin Davis</b>				14. MOTHER'S MAIDEN NAME <b>Sallie Terrell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>(Yes, no, or unknown)</b>		16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>		17. INFORMANT <b>Gwendolyn Bishop</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>420.1</b> (c) <b>stating the underlying cause lost.</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>420.1</b>						INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b> EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <b>Oct. 20, 1959</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/24/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ash Memorial,</b>		22d. LOCATION (City, town, or county) (State) <b>Sandy Spring, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden</b>				ADDRESS <b>Rockville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 27 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



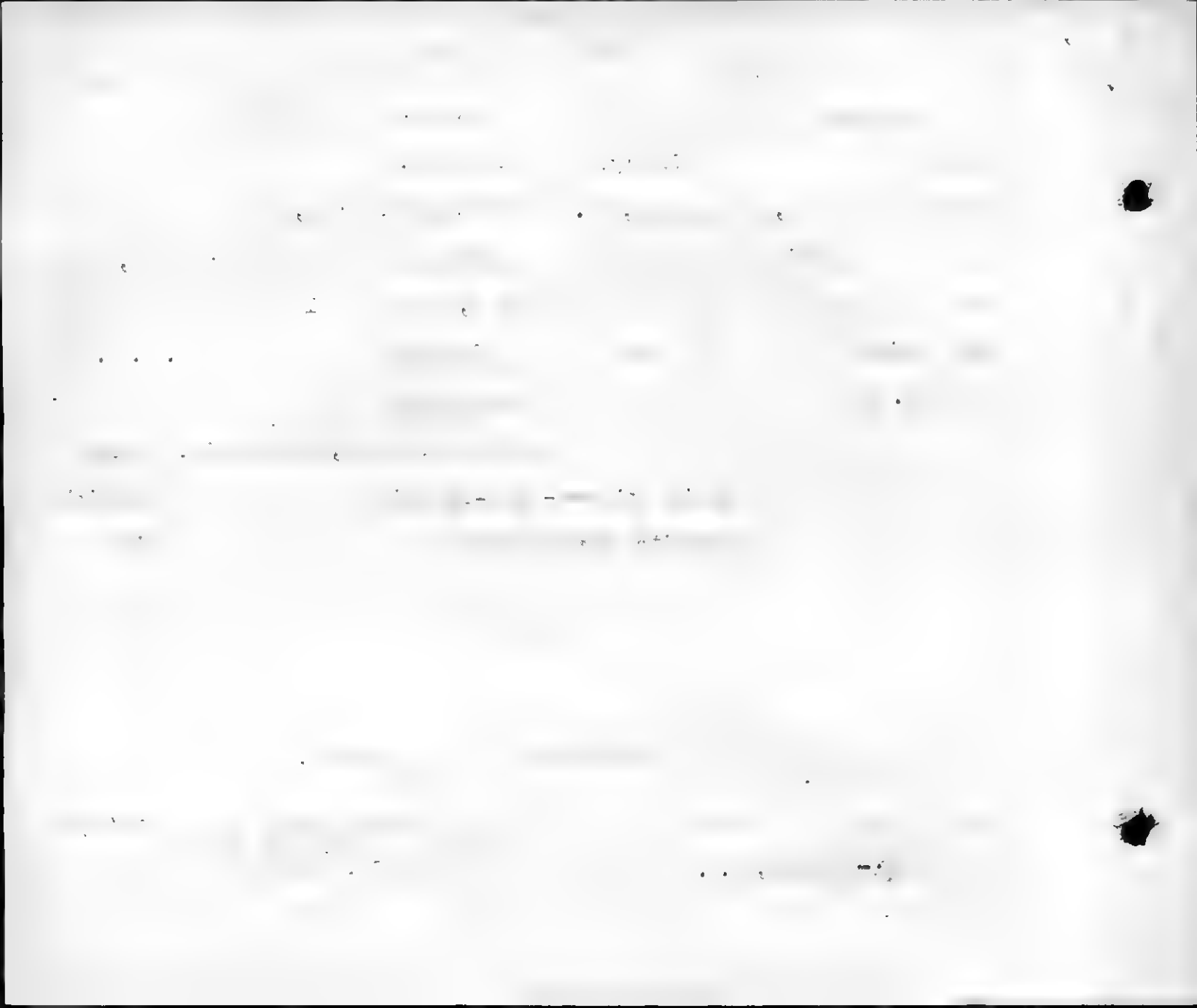
## CERTIFICATE OF DEATH

Reg. Dist. No.

11576

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Georgia</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>11 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Keith</b> Middle <b>Howard</b> Last <b>Davis</b>				4. DATE OF DEATH Month <b>October</b> Day <b>8</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 3, 1958</b>	
9. AGE (In years last birthday) <b>1</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None (Child)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>	
13. FATHER'S NAME <b>Howard E. Davis</b>				14. MOTHER'S MAIDEN NAME <b>Betty Cobble</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>The Medical Record</b>				Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure - post-operative</b>							
DUE TO (b) <b>Congenital heart disease</b>							
DUE TO (c) <b>Life</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19 WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <b>September 27 1959</b> , to <b>October 8, 1959</b> , that I last saw the deceased alive on <b>October 8, 1959</b> , and that death occurred at <b>9:35 PM</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>The Clinical Center</b>				DATE SIGNED <b>10/9/59</b>			
ACTUAL SIGNATURE <b>Roland Folse</b>				M.D. <b>The Clinical Center</b>			
PHYSICIAN'S NAME (Type) <b>Roland Folse, M.D.</b>				National Institutes of Health <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur. Trans.</b>		22b. DATE THEREOF <b>10-10-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Decatur, Georgia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>OCT 14 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Howard</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

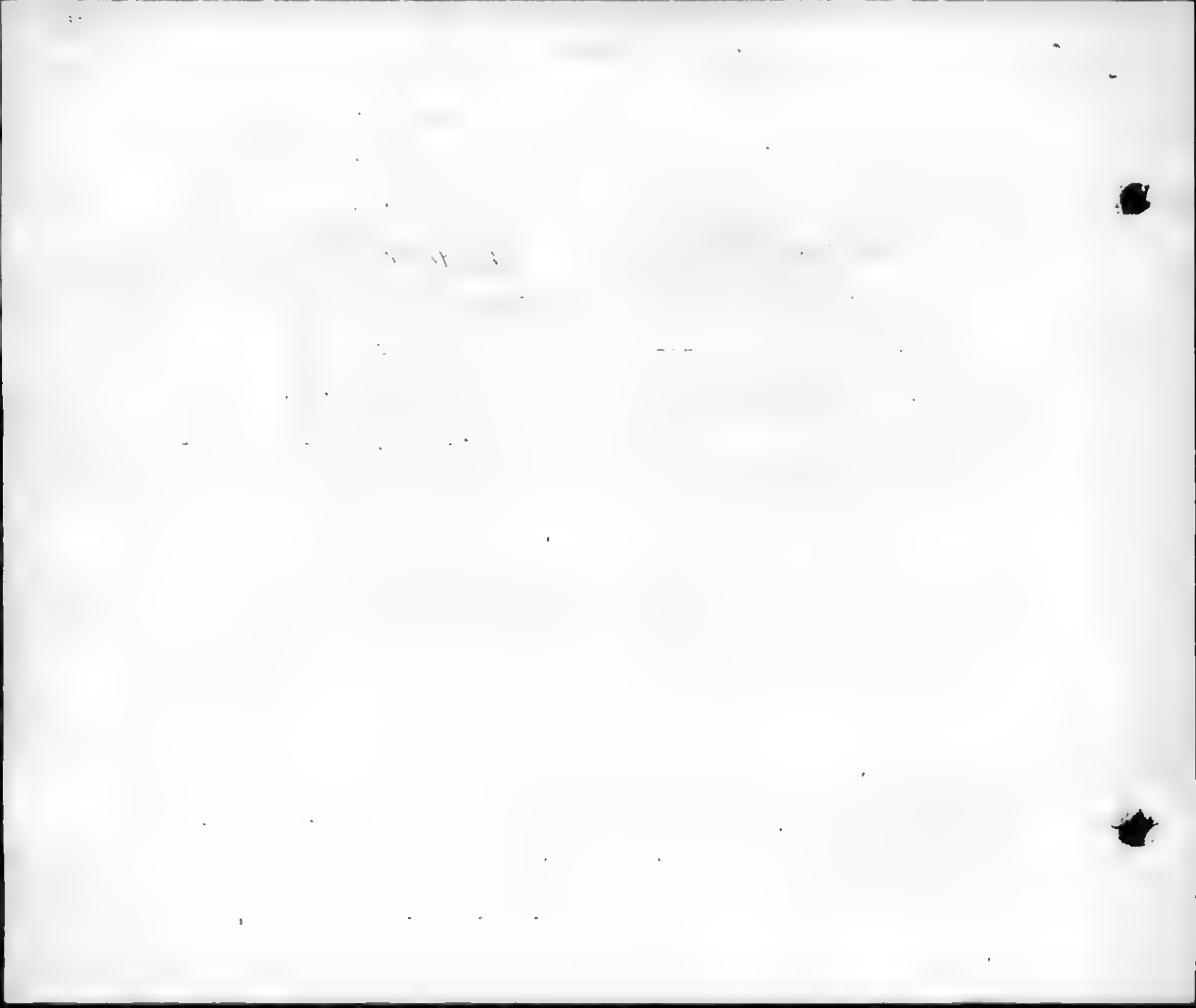
11525

## CERTIFICATE OF DEATH

Reg. Dist. No.

11577

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>10305 Montrose Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ETHEL</b> Middle <b>N</b> Last <b>DEMAREST</b>		4. DATE OF DEATH Month <b>10</b> Day <b>21</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/6/1874</b>
9. AGE (in years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>15</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Hamilton Smith Neale</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Bowden</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
INFORMANT <b>Catherine Demarest-daughter-same 2d</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Inanition</b> 4 <b>1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b> <b>years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Recent fracture, right femur</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July</b> , 19 <b>59</b> , to <b>10-21</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>10-21</b> , 19 <b>59</b> , and that death occurred at <b>5:30</b> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>JASON GEIGER</b>		ADDRESS (Street, city or town, state) <b>931 Pershing Drive, Silver Spring, Md.</b>	
PHYSICIAN'S NAME (Type) <b>JASON GEIGER, M.D.</b>		DATE SIGNED <b>10-21-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/24/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Christ Epis. Ch. Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Eastville, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		24a. REC'D BY REGISTRAR <b>Bethesda, Maryland</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		DATE <b>OCT 26 '59</b>	





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 21 Film G250 10-20-59 et

11578

CERTIFICATE OF DEATH

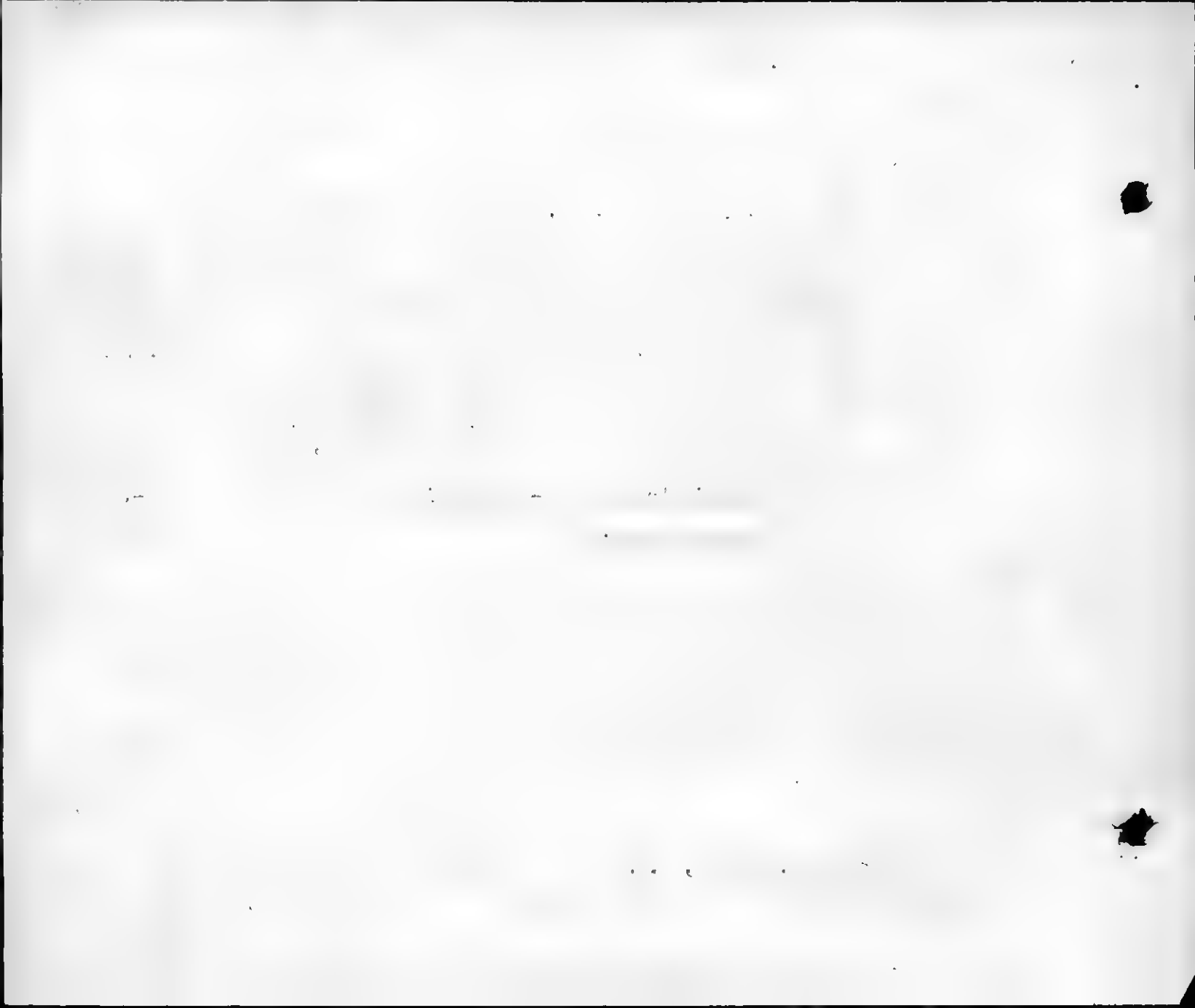
11526

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Ohio</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>7 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Jaye</b> Middle <b>Riley</b> Last <b>Diamond</b>				4. DATE OF DEATH Month <b>October</b> Day <b>14</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 21, 1923</b>	
9. AGE (In years last birthday) <b>36 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>VA Registrar</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>	
13. FATHER'S NAME <b>Terry Diamond</b>				14. MOTHER'S MAIDEN NAME <b>Mildred Riley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>				16. SOCIAL SECURITY NO <b>Unavailable</b>			
17. INFORMANT <b>The Medical Record</b>				Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Arrest-Hypotension</b> <b>204.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute Leukemia</b> DUE TO (c) <b>8 months</b> INTERVAL BETWEEN ONSET AND DEATH <b>6-8 hours</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <b>October 7, 19 59</b> to <b>October 14, 19 59</b> that I last saw the deceased alive on <b>October 14, 19 59</b> , and that death occurred at <b>2:50 AM</b> , from the causes and on the date stated above. <b>3:50 a.m.</b> ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>							
ACTUAL SIGNATURE <b>Charles E. Mengel, M.D.</b>				DATE SIGNED <b>10/14/59</b>			
PHYSICIAN'S NAME (Type) <b>Charles E. Mengel, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Trans.</b>		22b. DATE THEREOF <b>10-14-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rome Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Lawrence Co., Ohio</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>OCT 16 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11527

11533

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Washington D. C.</b> b. COUNTY <b>V</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>42X-3</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Manor Country Club</b>				d. STREET ADDRESS <b>6358-31st Street, N. W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>E</b> Last <b>Doane</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>5</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 8, 1912</b>	9. AGE (In years last birthday) <b>47</b> yrs.	10. IF UNDER 1 YEAR Months <b>4</b> Days <b>2</b>		11. IF UNDER 24 HRS. Hours <b>1</b> Min. <b>59</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lawyer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Oklahoma</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>John Wm. Doane</b>				14. MOTHER'S MAIDEN NAME <b>Dora Harden</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Vernon H Doane-brother-3802 Gramarcy St.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>420.1</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>p. m.</b> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-8-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>				24a. REC'D BY REGISTRAR <b>DATE OCT 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur P. Hanna</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 14 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 to the registrar. Forward to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 11528

11579

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Howard</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gastbury R-2</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pleasant View Nursing Home</u>		d. STREET ADDRESS <u>Daisy</u> <u>13X</u>	
3. NAME OF DECEASED (Type or print) First <u>Channing</u> Middle <u>Dorsey</u> Last <u>Dorsey</u>		4. DATE OF DEATH Month <u>10</u> Day <u>22</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>wh</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-20-1874</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>	11. BIRTHPLACE (State or foreign country) <u>md</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Hanson Dorsey</u>	
14. MOTHER'S MAIDEN NAME <u>unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>  </u>	
16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Mary Brown (daughter)</u> Address <u>Chesapeake N.J.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		DATE SIGNED <u>10-22-59</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/25/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Daisy</u>		22d. LOCATION (City, town, or county) (State) <u>Daisy, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. ...</u>		ADDRESS <u>Rockville, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>OCT 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 to the funeral home. Give Page 5 to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Reg. Dist. No. 11529											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>20 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9625 Alta Vista Terrace</u>					d. STREET ADDRESS <u>9625 Alta Vista Ter.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>Mary</u> Last <u>Dorsey</u>					4. DATE OF DEATH Month <u>Oct</u> Day <u>22</u> Year <u>1959</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>August 13, 1894</u>		9. AGE (In years last birthday) <u>65</u> yrs.			
						IF UNDER 1 YEAR Months <u>2</u> Days <u>9</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerical</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Contracting</u>			11. BIRTHPLACE (State or foreign country) <u>N. J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>		
13. FATHER'S NAME <u>Bodmer</u>					14. MOTHER'S MAIDEN NAME <u>A. Walsh</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>574-24-2775</u>		17. INFORMANT <u>Frank E. Dorsey - Son - Item #2</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>(1) Acute myocardial insufficiency</u> DUE TO (b) <u>(2) Coronary occlusion</u> DUE TO (c) <u>(3) hemorrhage into atheromateous plaque</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>										INTERVAL BETWEEN ONSET AND DEATH <u></u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>							
20c. TIME OF INJURY Hour <u></u> a. m. <u></u> p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) <u></u> (County) <u></u> (State) <u></u>				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>10-24-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>			22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>					24a. REC'D BY REGISTRAR <u>Oct 26 '59</u>			24b. REGISTRAR'S SIGNATURE <u>Charles S. Evans</u>			





## CERTIFICATE OF DEATH

Reg. Dist. No.

11530

11506

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>478</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1413 Floral St. N.W.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. &amp; Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>DOUGHERTY</u> Last <u>DOUGHERTY</u>		4. DATE OF DEATH Month <u>OCT.</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/1/76</u>
9. AGE (In years last birthday) <u>83</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Switzerland</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>	
INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u> DUE TO (b) <u>Coronary heart disease - arterial disease</u> DUE TO (c) <u>Interventricular - general</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan.</u> , 19 <u>59</u> , to <u>Oct 6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct 3</u> , 19 <u>59</u> , and that death occurred at <u>11:54</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward Heiges</u> M.D.		ADDRESS (Street, city or town, state) <u>6951 Ivy Branch Rd, Hill</u>	
PHYSICIAN'S NAME (Type) <u>EDWARD HEIGES, M.D.</u>		DATE SIGNED <u>10/6/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>10/9/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co. 2901-1548/177</u>		24a. REC'D BY REGISTRAR <u>OCT 8 '59</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hines</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11531

Reg. Dist. No.

11581

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>1400 Briggs-Chaney Rd. Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Home</b>		d. STREET ADDRESS <b>1400 Briggs-Chaney Rd</b>	
3. NAME OF DECEASED (Type or print) First <b>Eva</b> Middle <b>Willet</b> Last <b>Dowd</b>		DATE OF DEATH Month <b>10</b> Day <b>9</b> Year <b>1959</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-4-1875</b>
9. AGE (In years, month, day) <b>84</b>		IF UNDER 1 YEAR: Months <b>8</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>	
13. FATHER'S NAME <b>THOMAS WILLETT</b>		14. MOTHER'S MAIDEN NAME <b>PHOEBE BRANGHT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Mrs Dorothy Chandler</b> Address <b>1400 Briggs-Chaney Rd Silver Spring</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Stroke pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>80 days</b> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Osteoarthritis of spine</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10/5/59</b> to <b>10/9/59</b> , that I last saw the deceased alive on <b>10/5/59</b> , and that death occurred at <b>9:45 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. H. Ligon</b>		ADDRESS (Street, city or town, state) <b>Sandy Spring, Md.</b> DATE SIGNED <b>10/9/59</b>	
PHYSICIAN'S NAME (Type) <b>C. H. Ligon</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>10/14/59 GRACELAND</b>		22b. DATE THEREOF <b>10/14/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>SIoux CITY IOWA</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee FLINERAL Home</b> ADDRESS <b>4 St E</b>		24a. REC'D BY REGISTRAR <b>DATE OCT 15 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>			



11582

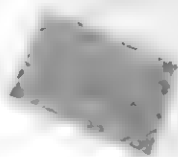
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY <u>Washington, D. C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>4 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Congressional Manor</u>		d. STREET ADDRESS <u>3200 - 16th. St., N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>J.</u> Last <u>Drew</u>		4. DATE OF DEATH Month <u>10</u> Day <u>5</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 29 1873</u>
9. AGE (In years last birthday) <u>86 yrs</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>6</u> Days <u>6</u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Principal of High Sch.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>SAN FRANCISCO, CALIF.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John R. Drew</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Roche</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Informant</u> Address <u>Item #2</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>3 yrs</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cancer of the Prostate &amp; recurrent urinary tract infection</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 <u>59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>55</u> to <u>60</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10/5</u> , 19 <u>59</u> , and that death occurred at <u>920 p. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Maurice Franks</u>		ADDRESS (Street, city or town, state) <u>901 - 20th. St., N.W.</u> DATE SIGNED <u>10-5-59</u>	
PHYSICIAN'S NAME (Type) <u>Maurice Franks, M.D.</u>		<u>Washington, D. C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-7-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	22d. LOCATION (City, town, or county) <u>Washington, D. C.</u> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>DET 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

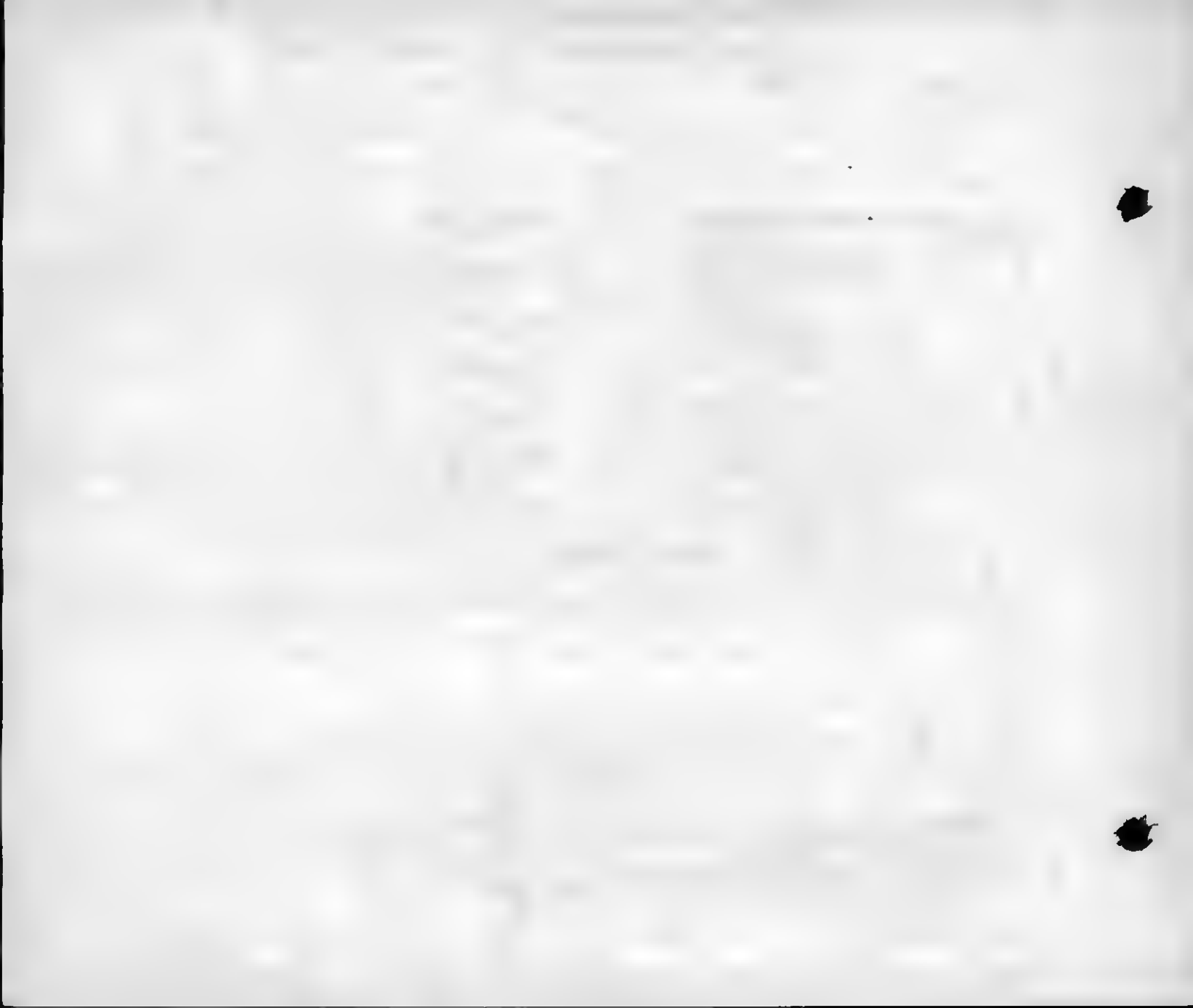
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11533

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Echo</u> c. LENGTH OF STAY IN 1b <u>4 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9 Bryn Mar Ave.</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick (rural)</u> d. STREET ADDRESS <u>RFD #4</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Beulah Mae Fagan</u> <b>4. DATE OF DEATH</b> Month Day Year <u>Oct 24 1959</u>		<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>3-2-1894</u> <b>9. AGE</b> (In years last birthday) <u>65</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>housewife</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>W. Dr.</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>W. Va.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.-C.</u>		<b>13. FATHER'S NAME</b> <u>Wm Luther Ammonette</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u> <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <input type="checkbox"/> <b>16. SOCIAL SECURITY NO.</b> <input type="checkbox"/> <b>17. INFORMANT</b> <u>John A Fagan</u> Address <u>721 Dist Ave</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>480-1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) _____ <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>CVA about 1 1/2 yrs ago</u> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b> <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town)</b> _____ <b>(County)</b> _____ <b>(State)</b> _____		<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .	
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschalt</u> <b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Broschalt</u>		<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>10-2K-59</u>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>22b. DATE THEREOF</b> <u>10/26/59</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Linwood Cem.</u> <b>22d. LOCATION (City, town, or county)</b> <u>Linwood, W. Va.</u>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Cherry Phoenix Funeral Home</u> <b>ADDRESS</b> <u>5100 N. Main St.</u> <b>24a. REC'D BY REGISTRAR</b> <u>OCT 28 '59</u> <b>24b. REGISTRAR'S SIGNATURE</b> _____	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





11584

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

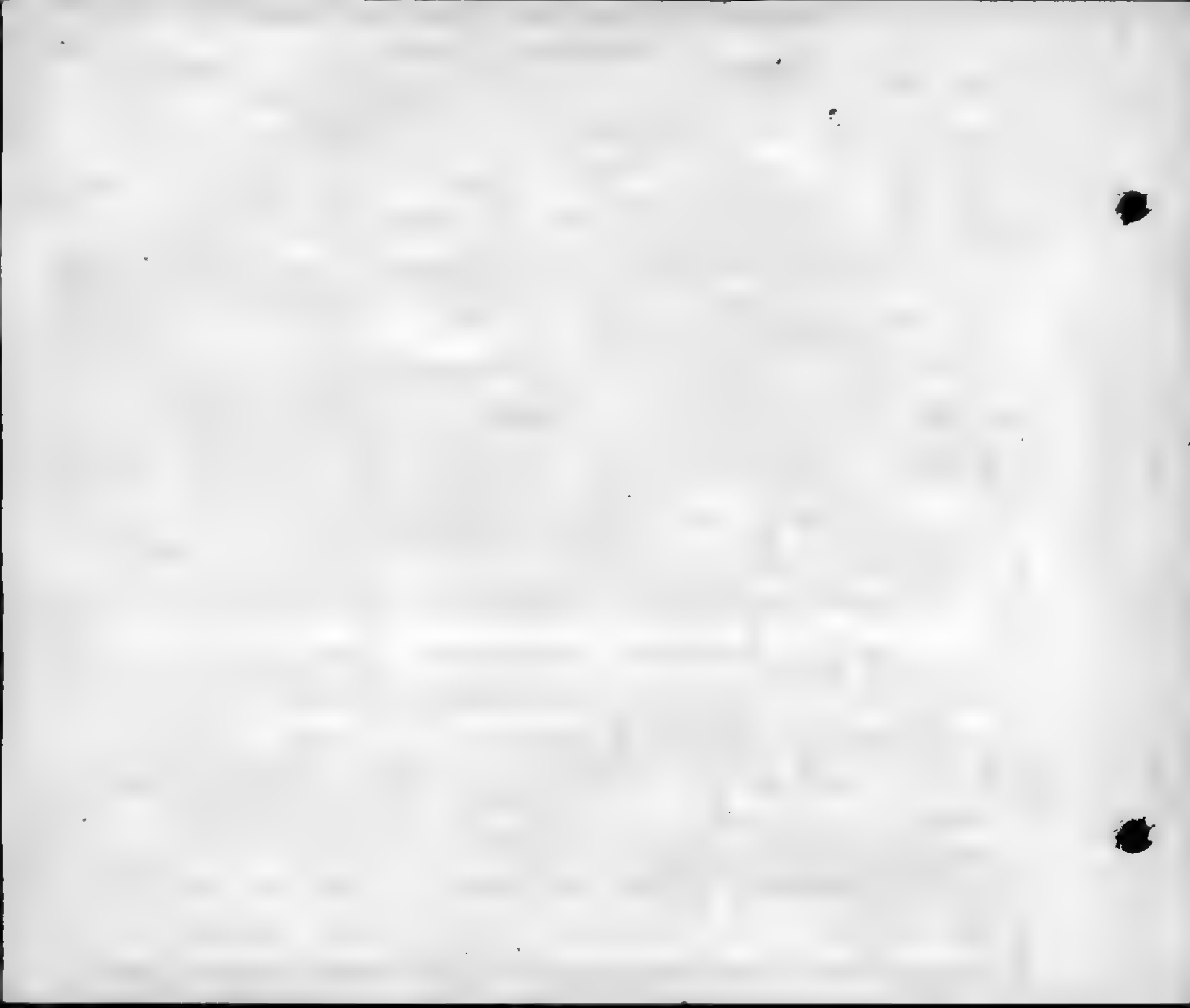
Reg. Dist. No.

11534

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Oakville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Philomina Rest Home</u>		d. STREET ADDRESS <u>4018 S. Capitol St. SE</u>	
3. NAME OF DECEASED (Type or print) <u>Kathleen W. Fairall</u>		4. DATE OF DEATH <u>Oct 1 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/24/1905</u>
9. AGE (In years last birthday) <u>54</u>		10. IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Health Research</u>	
11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas Whalen</u>		14. MOTHER'S MAIDEN NAME <u>Mary Hines</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Nursing Home Resident</u>	
17. INFORMANT <u>St. Philomina Rest Home</u>		Address <u>14901 G.C. Ave. Kalamazoo</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dehydration</u> DUE TO <u>Multiple Sclerosis</u> (b) <u></u> DUE TO <u></u> (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/7</u> , 1959, to <u>10/1</u> , 1959, that I last saw the deceased alive on <u>9/28</u> , 1959, and that death occurred at <u>7:35 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. H. Higgin</u>		ADDRESS (Street, city or town, state) <u>Jandy Spring, Md.</u>	
PHYSICIAN'S NAME (Type) <u>C. H. Higgin</u>		DATE SIGNED <u>10/1/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-5-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ardenwood</u>		22d. LOCATION (City, town, or county) (State) <u>Ardenwood, Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur A. Mettling</u>		ADDRESS <u>131 W. 1st St. Wash DC</u>	
24a. REC'D BY REGISTRAR <u>Arthur A. Mettling</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur A. Mettling</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11507

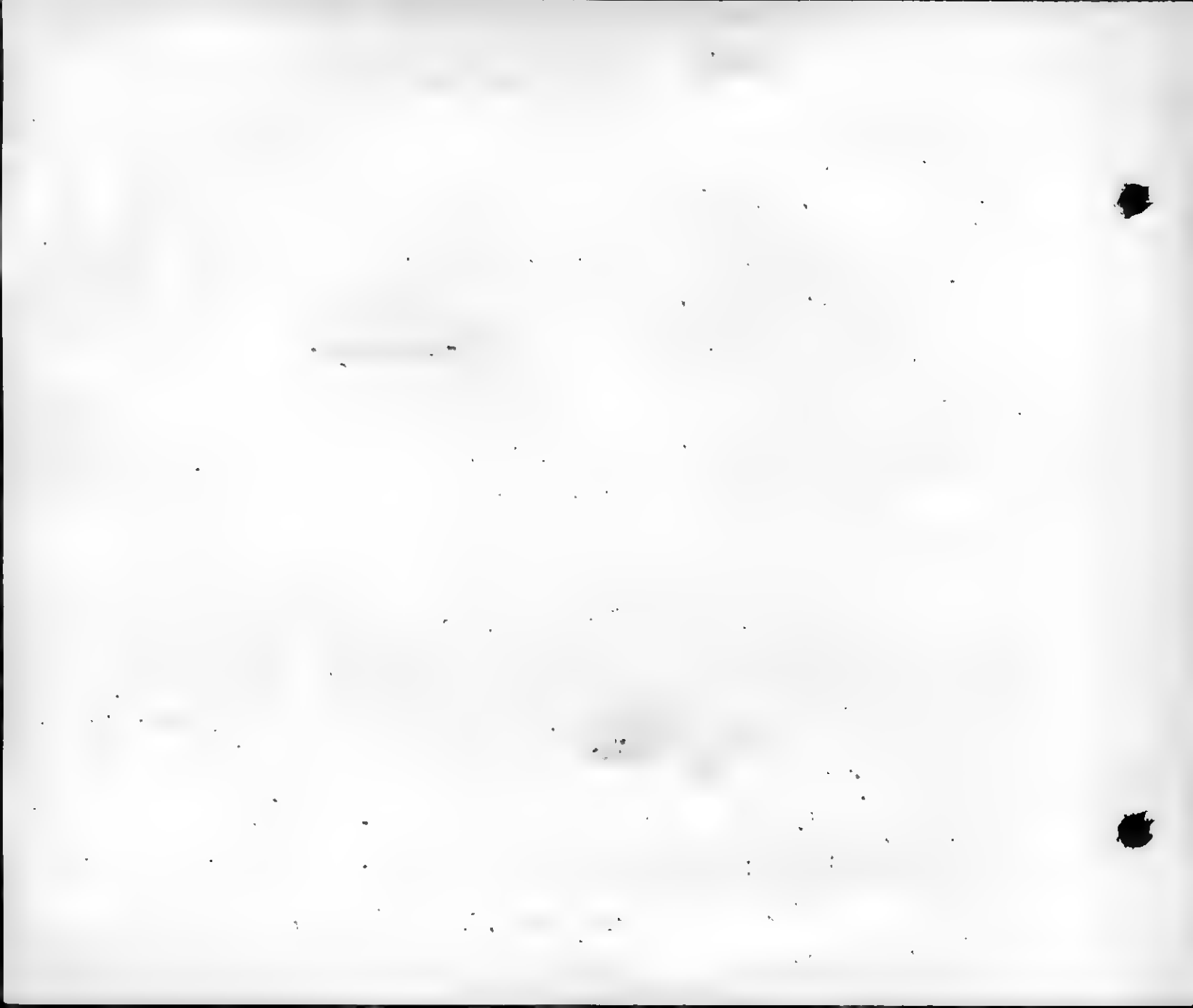
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>3 wks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. San &amp; Hosp</u>				e. STREET ADDRESS <u>8401 11th Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Fannie</u> Middle <u>Maude</u> Last <u>Farrell</u>				4. DATE OF DEATH Month <u>10</u> Day <u>3</u> Year <u>1959</u>			
5 SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2-1-1873</u>	9 AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Months Days Hours Min	10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY —		11 BIRTHPLACE (State or foreign country) <u>Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>James L. Hensell</u>				14. MOTHER'S MAIDEN NAME <u>Martha Farrell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16 SOCIAL SECURITY NO. <u>no</u>			
17. INFORMANT <u>From Patients Chart</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> (myocardial degeneration) <u>422.2</u> DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of left hip Sept 8-59</u>							
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Accident, fell in room.</u>			
20c TIME OF INJURY Month, Day, Year Hour <u>9-8</u> a. m. <u>1959</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f (City or town) <u>Silver Spring</u>				20g (County) <u>Montgomery</u>		20h (State) <u>md.</u>	
21. I certify that I attended the deceased from <u>Mar</u> , 19 <u>59</u> , to <u>Oct 3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct 3</u> , 19 <u>59</u> , and that death occurred at <u>11:25 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John N. Andrews</u>				ADDRESS (Street, city or town, state) <u>9601 Colesville Rd</u>			
PHYSICIAN'S NAME (Type) <u>John N. Andrews</u>				DATE SIGNED <u>10-3-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>				22b. DATE THEREOF <u>10/6/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Barton, Florida</u>				22e. (State) <u>Florida</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>The St. James Co.</u>				ADDRESS <u>Wash. D. C.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 6 59</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles E. Kinn</u>							

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11585

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Asbury Methodist Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARGARET</u> First Middle Last		4. DATE OF DEATH <u>10</u> Month <u>5</u> Day <u>1959</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 15 - 1870</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Asbury Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Augusta Ga</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Calvert Fifer</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Pfeiffer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Asbury Home Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of head of pancreas</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>12-12</u> , 19 <u>59</u> to <u>10-5</u> , 19 <u>59</u> that I last saw the deceased alive on <u>OCT 4</u> , 19 <u>59</u> , and that death occurred at <u>9:40</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sarah E. Glover</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>10-5-59</u>	
PHYSICIAN'S NAME (Type) <u>Sarah E. Glover</u>		<u>Monsington, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-7-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>	22d. LOCATION (City, town, or county) (State) <u>Gaithersburg Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner, Gaithersburg, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 7 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur J. Kenna</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11586

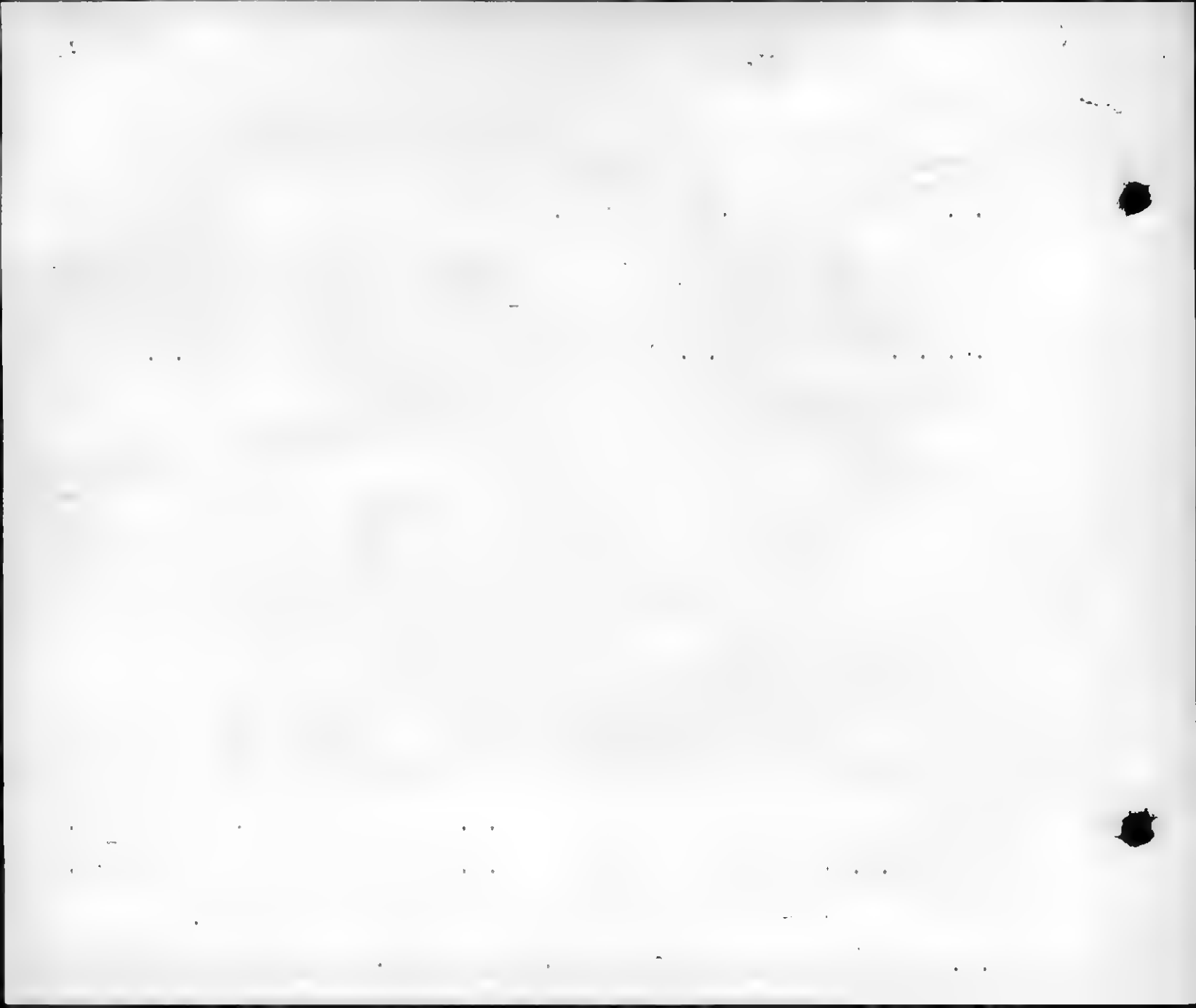
## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN lb <b>64 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>South Carolina</b> b. COUNTY <b>Parris Island</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>77x</b> d. STREET ADDRESS <b>Box 644</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Richard Edwin FILLBACH</b>		4. DATE OF DEATH Month Day Year <b>October 7 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-7-22</b>
9. AGE (In years last birthday) <b>37</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S.A.F.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>	
11. BIRTHPLACE (State or foreign country) <b>Wisconsin</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>George FILLBACH</b>		14. MOTHER'S MAIDEN NAME <b>Ann BRENNAN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>(Wife) Mary Fillbach</b>	
17. ADDRESS <b>Same as #2</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY FAILURE</b> 200.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>APLASTIC BONE MARROW</b> DUE TO (c) <b>RETICULUM CELL SARCOMA, PRIMARY BONE</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b> INTERVAL BETWEEN ONSET AND DEATH <b>24 HOURS</b> <b>2 WEEKS</b> <b>20 MOS.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <b>NONE</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>NONE</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4 August 1959</b> to <b>7 October 1959</b> that I last saw the deceased alive on <b>7 October 1959</b> , and that death occurred at <b>3:10A</b> PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda Md. 10-7-59</b>			
ACTUAL SIGNATURE <b>G.B. Townsend</b>		M.D. <b>U.S. Naval Hospital, Bethesda Md.</b>	
PHYSICIAN'S NAME (Type) <b>G.B. TOWNSEND LT MC USN</b>		U.S. Naval Hospital, Bethesda Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-13-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. PUMPHREY</b>		24a. REC'D BY REGISTRAR <b>13 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kline</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11538

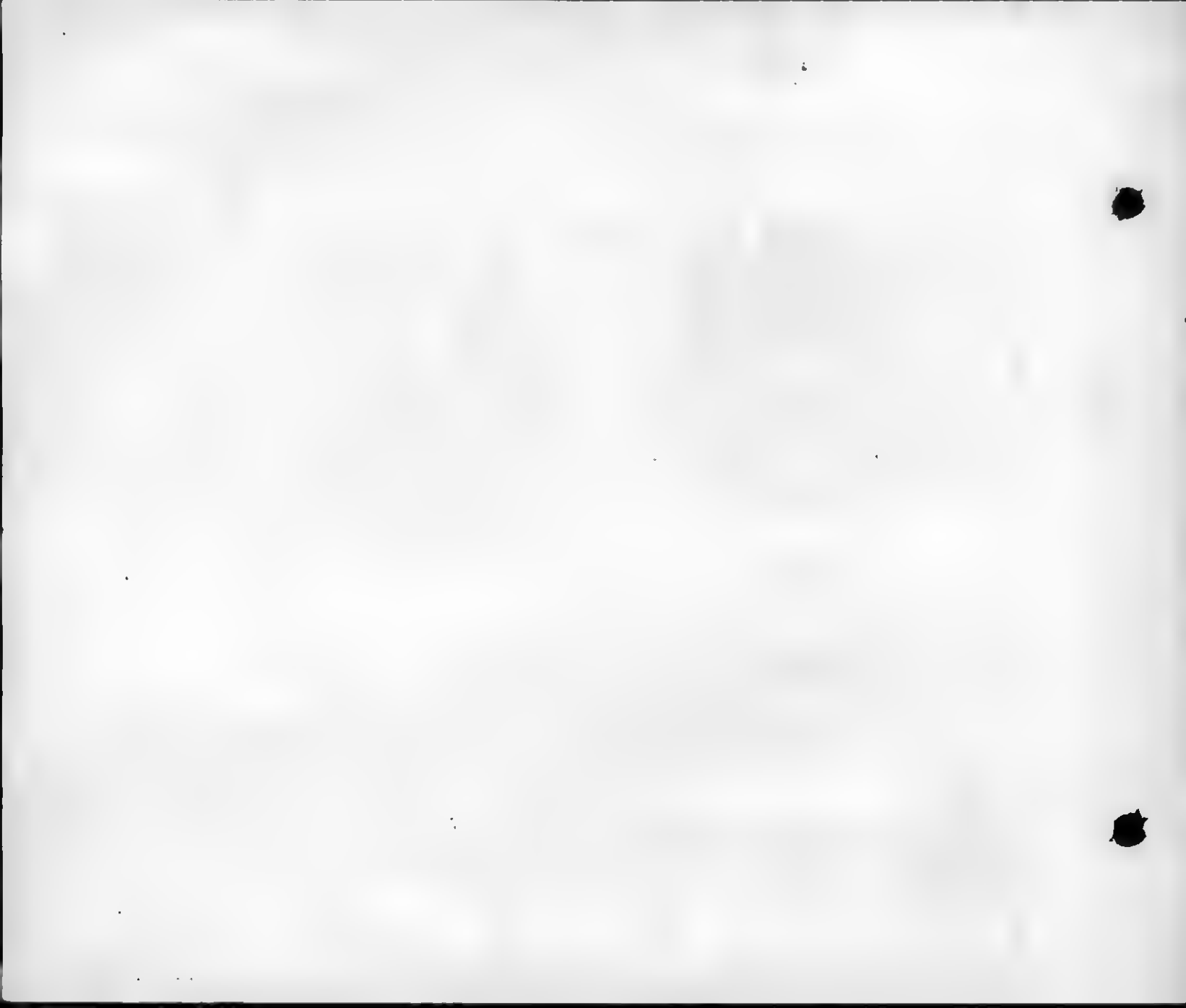
11587

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>4914-CRESCENT ST.</b>	
3. NAME OF DECEASED (Type or print) <b>CATHERINE FRANCES FITZGERALD</b>		4. DATE OF DEATH Month <b>10</b> Day <b>13</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB 23<sup>RD</sup>, 1899</b>
9. AGE (In years last birthday) <b>60</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours M. n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>WASHINGTON DC</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES FRANCIS KELLEY</b>		14. MOTHER'S MAIDEN NAME <b>CATHERINE FALVEY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO	
17. INFORMANT <b>HELEN O'BRIEN</b>		Address <b>1228-BUCHANAN ST N.E.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral arteriosclerosis</b> (c) <b>Diabetes mellitus</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>5 11</b> <b>Unknown</b> <b>1936</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>Sept 1954</b> to <b>Oct 1959</b> , that I last saw the deceased alive on <b>Oct 13 1959</b> , and that death occurred at <b>7:42 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Francis J. Murray M.D. 2111 Bancroft Pl NW 10/13/59</b>			
ACTUAL SIGNATURE <b>Francis J. Murray</b> M.D. 2111 Bancroft Pl NW 10/13/59			
PHYSICIAN'S NAME (Type) <b>FRANCIS J. MURRAY Wash 8 DC</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<b>Burial</b>		<b>10/17/59</b>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>St. Agnes</b>		<b>Wash. D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
<b>Anthony Paulson</b>		<b>DATE OCT 21 59</b>	
ADDRESS <b>3831 Pa Ave NW</b>		24b. REGISTRAR'S SIGNATURE <b>Oct 21 1959</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

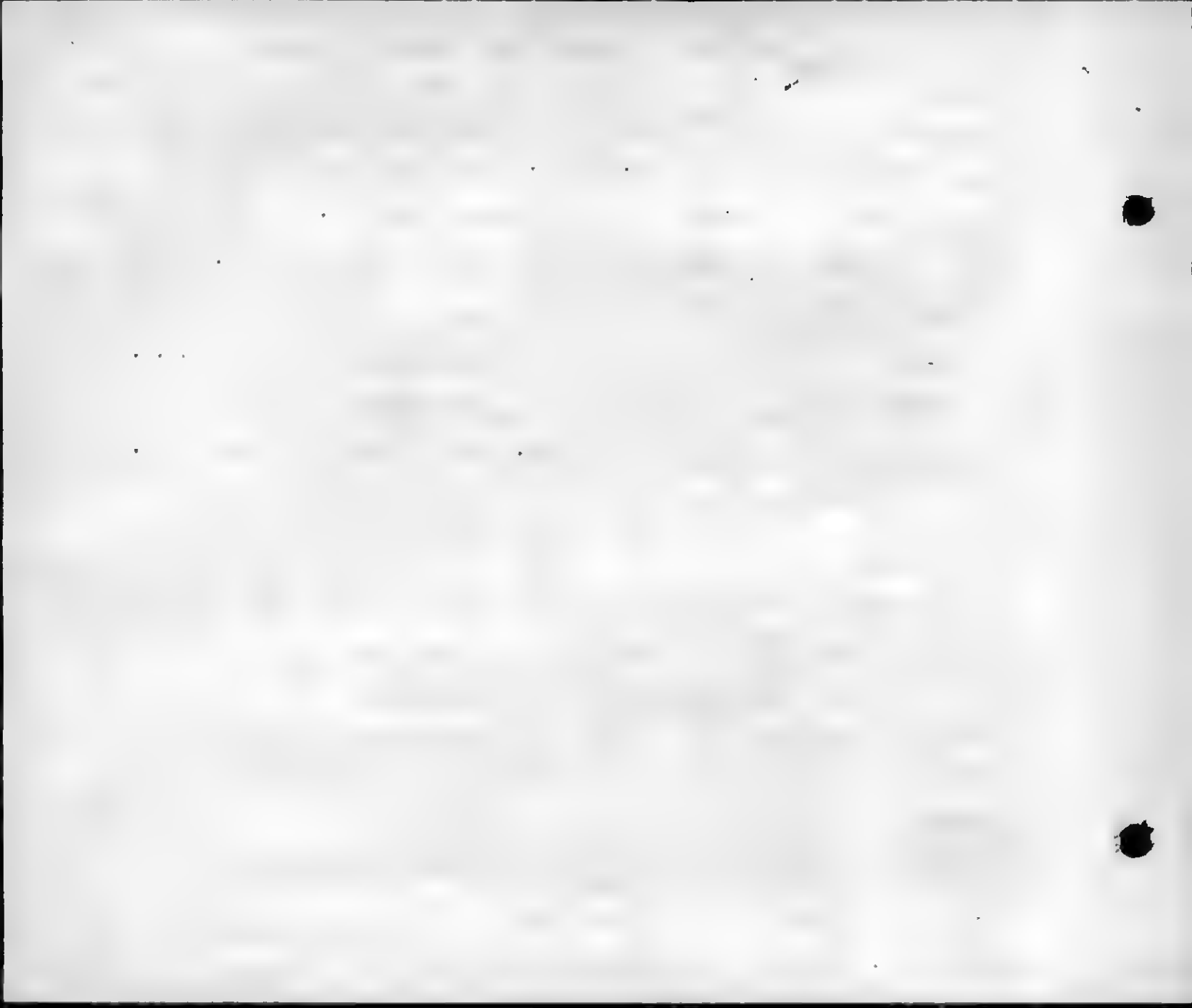
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11539

11588

1. PLACE OF DEATH a. COUNTY <b>Montgomery MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. LENGTH OF STAY IN 1b <b>1 Hr. 20 Min.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban</b>				d. STREET ADDRESS <b>309 Howard Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Amos</b> Middle <b>Walker</b> Last <b>Flanary</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>17</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1903</b>		9. AGE (In years last birthday) <b>56</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Flanary</b>				14. MOTHER'S MAIDEN NAME <b>Mary Lawson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Mrs. Annie Flanary</b> Address <b>309 Howard Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage &amp; laceration</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Bullet wound Thru skull</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>self inflicted bullet wound</b>					
20c. TIME OF INJURY Month, Day, Year <b>10-15 P. m. 10-16 1959</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Rockville Monty md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>FRANK J. Broschart</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>10-17-59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit</b>		22b. DATE THEREOF <b>10/22/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Millers Chapel</b>		22d. LOCATION (City, town, or county) (State) <b>Pennington Grove, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>2059</b>	
				24b. REGISTRAR'S SIGNATURE <b>William S. Kama</b>			



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**CERTIFICATE OF DEATH**

11540

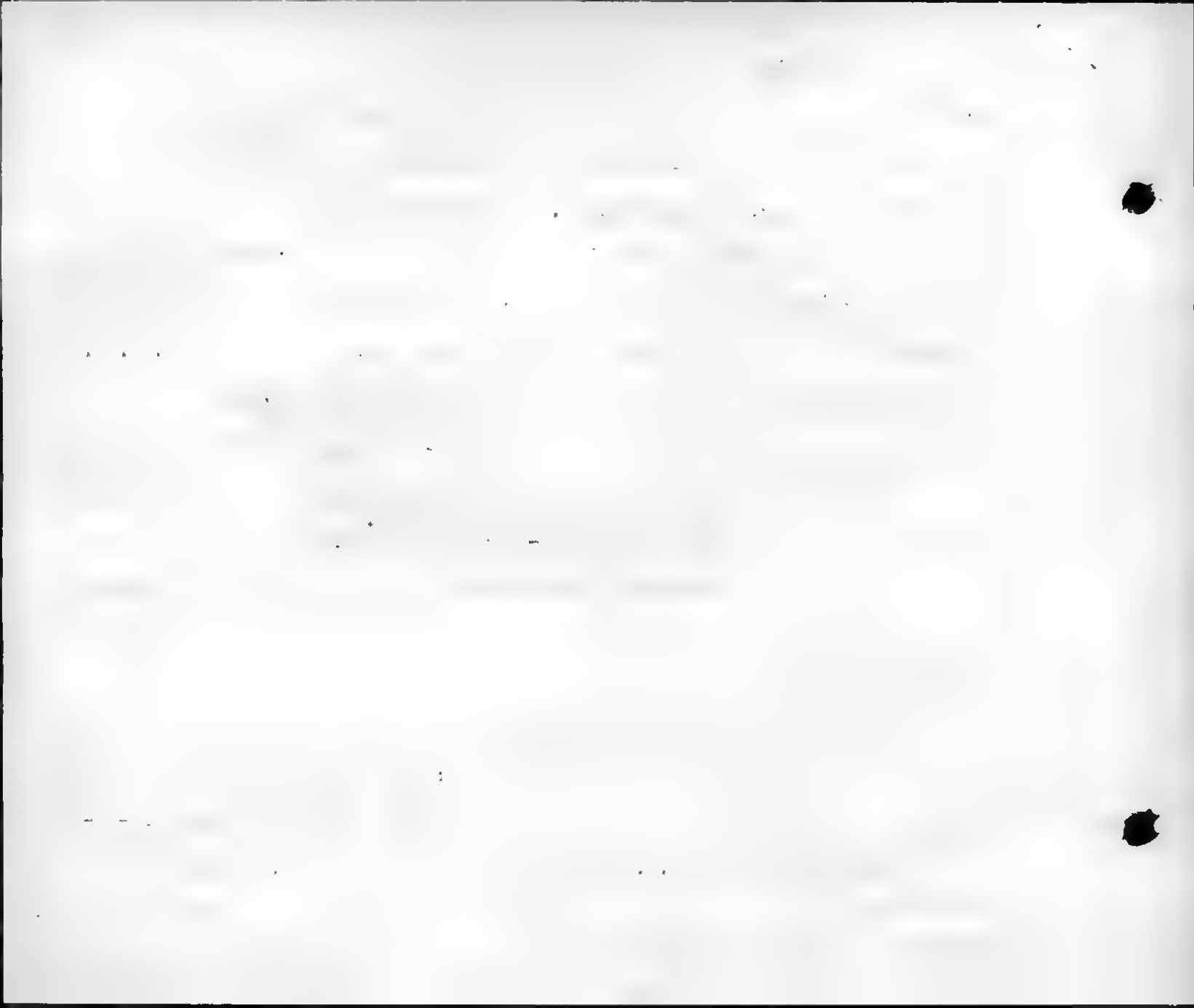
Reg. Dist. No.

11589

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>North Carolina</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN lb <b>19 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greensboro</b> 70x	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>1110 Bellevue Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Blanche Estelle Fogleman</b>		4. DATE OF DEATH Month Day Year <b>October 16, 1959</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 13, 1905</b>		9. AGE (In years lost birthday) <b>54</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Hugh Thomas Ryder</b>				14. MOTHER'S MAIDEN NAME <b>Pamela Caroline Staley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation secondary to Progressive Cardiac Failure.</b> DUE TO (b) <b>Closure of Atrio-Ventricular Canal</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Congenital Heart Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>  <b>3 days</b>  <b>Birth</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>September 27, 1959</b> to <b>October 16, 1959</b> , that I last saw the deceased alive on <b>October 16, 1959</b> , and that death occurred at <b>7:40 P.M.</b> from the causes and on the date stated above. <b>6:40 p.m.</b> ADDRESS (Street, city or town, state) DATE SIGNED <b>The Clinical Center 10-17-59</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>							
ACTUAL SIGNATURE <i>[Signature]</i> M.D.				22a. NAME OF CEMETERY OR CREMATORY <b>Forest Lawn Cem.</b>			
PHYSICIAN'S NAME (Type) <b>LAZAR GREENFIELD, M.D.</b>				22b. LOCATION (City, town, or county) (State) <b>Guilford County, No. Car.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b> Bethesda, Md.				24a. REC'D BY REGISTRAR DATE <b>OCT 20 1959</b>		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



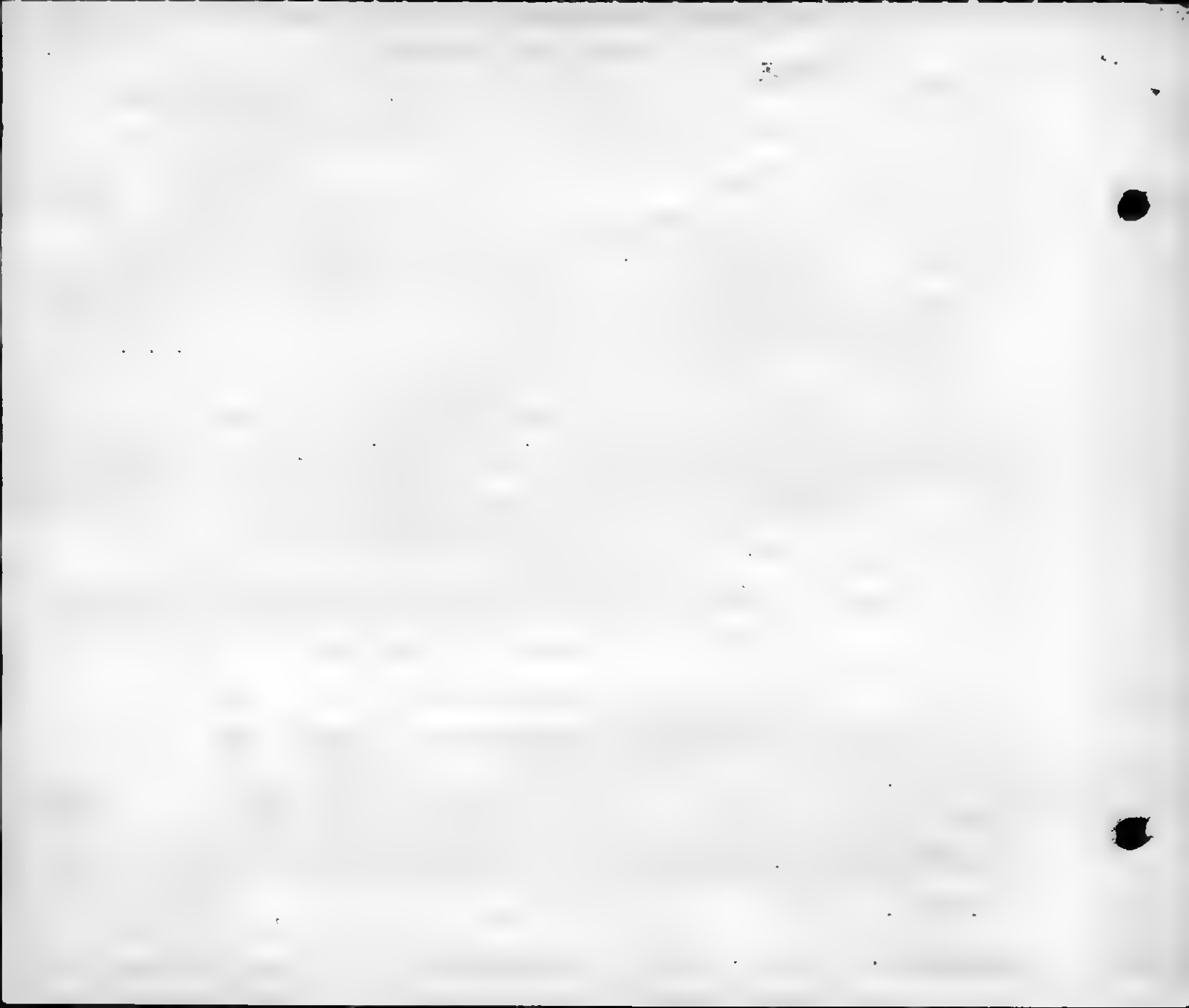
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>210 Baltimore Road</b>		e. STREET ADDRESS <b>210 Baltimore Road</b>	
3. NAME OF DECEASED (Type or print) First <b>JENNIE</b> Middle <b>M.</b> Last <b>FREEMAN</b>		4. DATE OF DEATH Month <b>October</b> Day <b>6</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 3, 1881</b>
9. AGE (In years last birthday) yrs. <b>78</b>		IF UNDER 1 YEAR Months <b>2</b> Days <b>3</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>New York</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Unknown</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Daughter-in-law</b> Address <b>Mrs. Maxwell M. Freeman - Item #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ARTERIAL HYPERTENSION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>GENERALIZED ARTERIOSCLEROSIS</b> DUE TO (c) <b>CORONARY THROMBOSIS</b>			INTERVAL BETWEEN ONSET AND DEATH <b>20 YEARS</b> <b>20 YEARS</b> <b>7 DAYS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PARTIAL SINUS</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>September 28, 1959</b> to <b>October 6, 1959</b> that I last saw the deceased alive on <b>October 6, 1959</b> , and that death occurred at <b>5 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Gordon S. Rosenberger</b>		DATE SIGNED <b>6 Oct 1959</b>	
PHYSICIAN'S NAME (Type) <b>Gordon S. Rosenberger</b>		ADDRESS (Street, city or town, state) <b>26th Street, N.W.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur. Trans.</b>	22b. DATE THEREOF <b>10-9-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Fern Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Stuart, Florida</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 13 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## CERTIFICATE OF DEATH

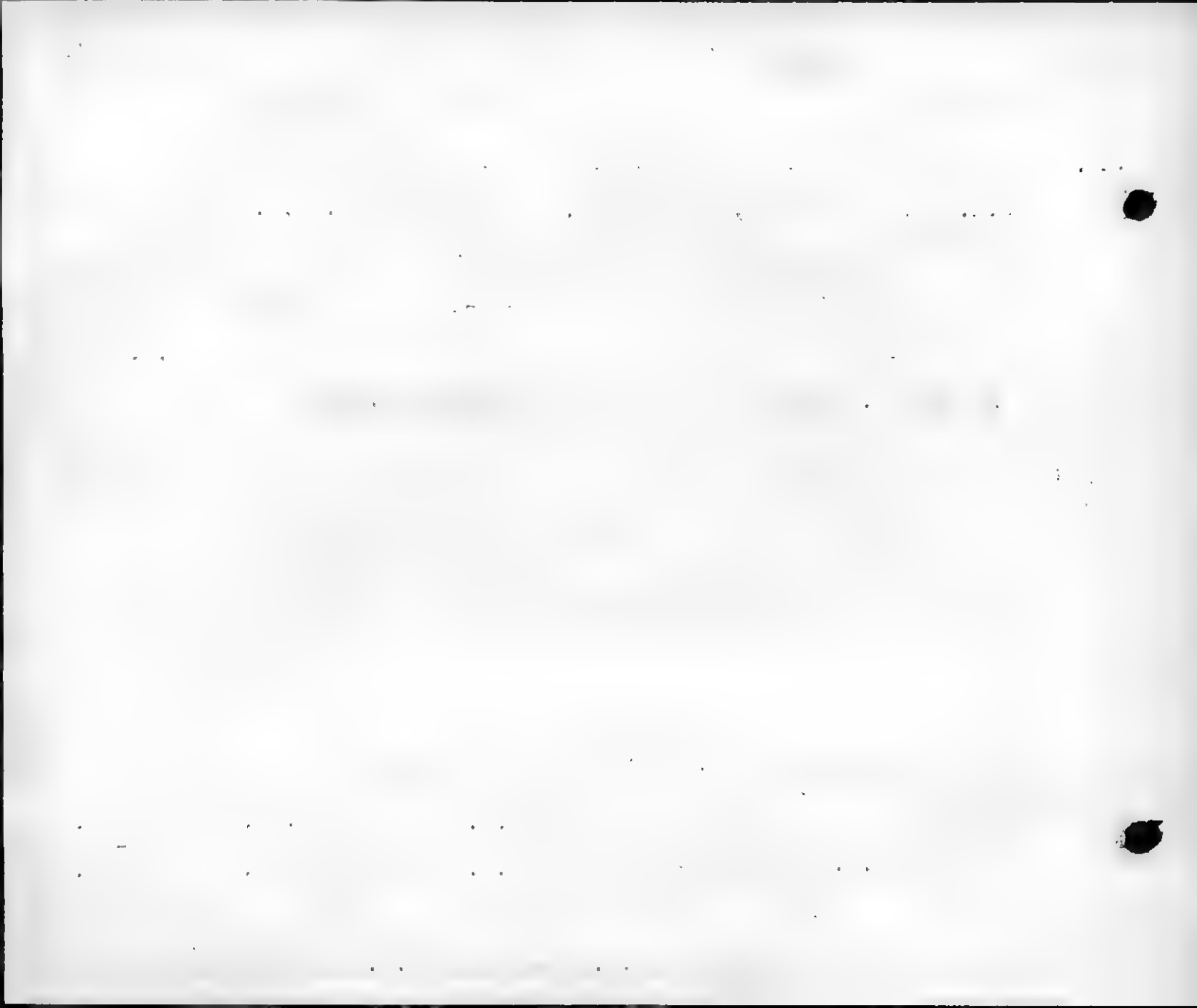
Reg. Dist. No. 215

11590

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>50 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>4...</b> d. STREET ADDRESS <b>501 Seward St. S.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Margaret J FREEMAN</b>			4. DATE OF DEATH Month Day Year <b>October 2 1959</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <b>6-11-15</b>		9. AGE (In years last birthday) <b>44 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>William N. ELLIS</b>			14. MOTHER'S MAIDEN NAME <b>Maggie E. ALVEY</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		INFORMANT Address <b>Hospital records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Infection of Myocardium</b> DUE TO (b) <b>Diabetes Mellitus</b> DUE TO (c) <b>Diabetes Mellitus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>20 MIN</b>					INTERVAL BETWEEN ONSET AND DEATH <b>20 MIN</b>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>			
21. I certify that I attended the deceased from <b>13 August 1959</b> to <b>2 October 1959</b> that I last saw the deceased alive on <b>2 October 1959</b> and that death occurred at <b>8:00AM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda Md. 10-2-59</b>							
ACTUAL SIGNATURE <b>R.G. Muth</b>		M.D. <b>U.S. Naval Hospital, Bethesda Md.</b>					
PHYSICIAN'S NAME (Type) <b>R.G. MUTH LT MC USN</b>		<b>U.S. Naval Hospital, Bethesda Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-5-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>			
22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Matthew 131 11th Street S.E. Washington D.C.</b>		24a. REC'D BY REGISTRAR <b>OCT 7 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11591

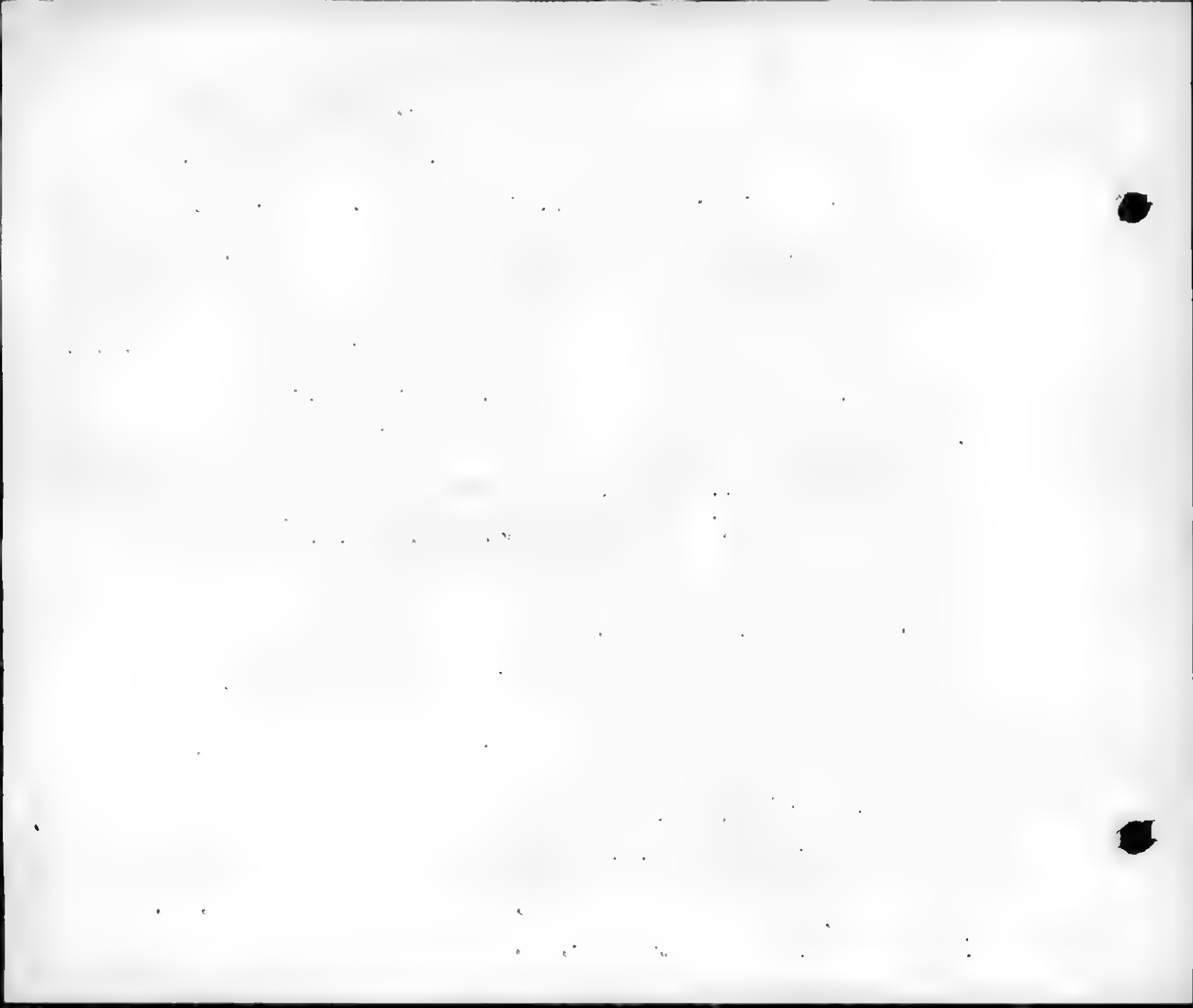
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Norbeck</b>	c. LENGTH OF STAY IN 1b <b>3 hours</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sandy Spring, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sewell's Maternity Hosp.</b>		d. STREET ADDRESS <b>Norbeck, Rt. 1 Silver Spring</b>	
3. NAME OF DECEASED (Type or print) First <b>Male</b> Middle <b>Baby</b> Last <b>Gaines</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>21</b> Year <b>1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 21, 59</b>
9. AGE (In years last birthday) <b>0</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>3</b> Hours <b>0</b> Min <b>0</b>	IF UNDER 24 HRS <b>3</b> Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>fetus</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Norbeck Rt. 1 Silv. Sp. U.S.A.</b>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Leslie I. Gaines</b>	
14. MOTHER'S MAIDEN NAME <b>L. Bernice Stewart</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO		17. INFORMANT <b>mother Sandy Spring, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1. Preeclamptic Toxemia in mother</b> 769.0 DUE TO <b>2. Cord about neck twice around.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>3. Prolonged Labor Oct. 18 a.m. to Oct. 21</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Mother Diabetic; age 41.</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Autopsy report from Suburban Hospital</b>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 21 12:05 a.m. to 3:30 a.m.</b> and that death occurred at <b>3:30 a.m.</b> last saw the deceased alive on <b>Oct. 21 59</b> , 19 <b>59</b> , and that death occurred on the date stated above.			
ACTUAL SIGNATURE <b>Webster Sewell</b>		DATE SIGNED <b>10.22.59</b>	
PHYSICIAN'S NAME (Type) <b>Webster Sewell, M.D.</b>		<b>Norbeck, Rt. 1 Silver Spring, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Type)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>10/23/59</b>	<b>Ash Memorial,</b>	<b>Sandy Spring, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Sander</b>		ADDRESS <b>Rockville, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>OCT 27 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kenna</b>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11508

## CERTIFICATE OF DEATH

Reg. Dist. No. 11544

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cash &amp; Co's Hosp. Takoma Park Md. 9819 Colinet Pl.</u>				d. STREET ADDRESS <u>560 Silver Springs</u>			
3. NAME OF DECEASED (Type or print) <u>D'Arcy Gerald Gallagher</u>				4. DATE OF DEATH <u>Oct. 25 1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-1-1916</u>	9. AGE (In years last birthday) <u>43</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min		IF UNDER 74 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Army Ordnance - Dist. (supervisor)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Canada N.Y.</u>		11. BIRTHPLACE (State or foreign country) <u>Canada</u>	
13. FATHER'S NAME <u>John Gallagher</u>				14. MOTHER'S MAIDEN NAME <u>Frances O'Neill</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WORLD WAR II</u>				16. SOCIAL SECURITY NO. <u>Hospital Chart</u>			
17. INFORMANT <u>Hospital Chart</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction, postural</u>							<u>15 days</u>
DUE TO <u>420.1</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) <u>Coronary atherosclerosis</u>							<u>2 years</u>
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>8-14 1959</u> to <u>10-25 1959</u> , that I last saw the deceased alive on <u>10-24 1959</u> , and that death occurred at <u>6:05 PM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>James T. Kunkle</u>				M.D. <u>929 Plucking Ave</u> <u>10-25-59</u>			
PHYSICIAN'S NAME (Type) <u>Silver Springs, Md.</u>							
22a. (BURIAL) CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>OCT. 29, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATL</u>	22d. LOCATION (City, town, or county)	(State)			
				<u>ARLINGTON VA.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Warren Taltavell</u>				ADDRESS <u>3603-16th St. NW</u>	24. REC'D BY REGISTRAR DATE <u>OCT 28 '59</u>	24b. REGISTRAR'S SIGNATURE <u>William S. Kunkle</u>	
				<u>Wash. D.C.</u>		<u>OCT 28 '59</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

11592

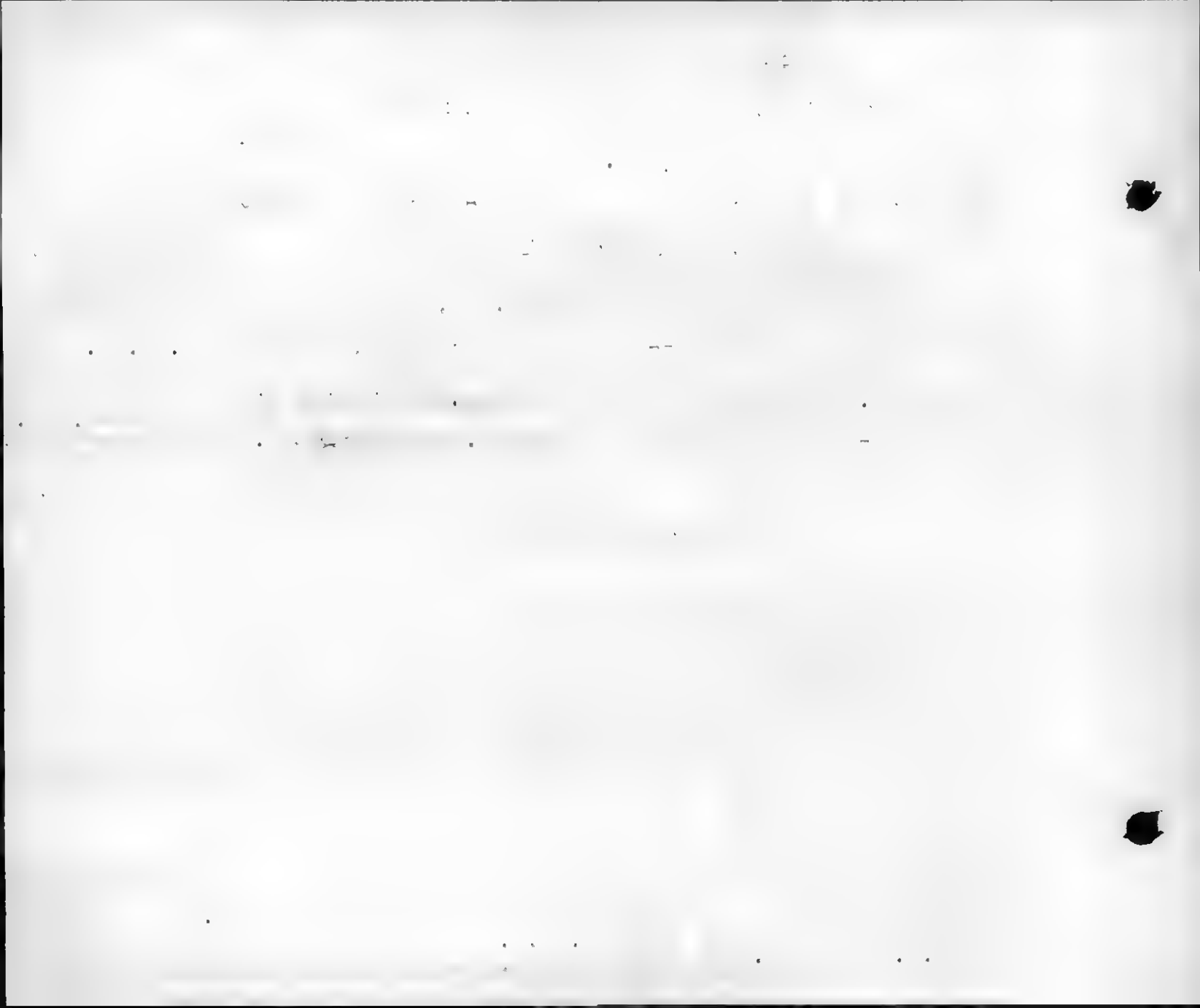
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>4 mo.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4503 Traymore Street</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Elizabeth Louise Gallahorn</b>		4. DATE OF DEATH Month Day Year <b>10/17 19 59</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 16, 1875</b>
9. AGE (In years last birthday) <b>83</b> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11. BIRTHPLACE (State or foreign country) <b>Alexandria, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Charles R. Brill</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Louise Niter</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>none</b>	
17. INFORMANT <b>James T. Gallahorn, Jr.</b>		Address <b>Bethesda, Md. 4503 Traymore St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebro-Vascular Accident</b> DUE TO <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>20 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma Cervix Uteri - 5 years</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 15</b> , 19 <b>57</b> , to <b>Oct 16</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Oct 14</b> , 19 <b>59</b> , and that death occurred at <b>10:45 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Arthur H. Lewis</b>		ADDRESS (Street, city or town, state) <b>1714 R. J. Ave NW Washington D.C.</b>	
PHYSICIAN'S NAME (Type) <b>ARTHUR H. LEWIS</b>		DATE SIGNED <b>Washington D.C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>10/20/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		24a. REC'D BY REGISTRAR <b>OCT 20 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>William S. Hunt</b>			

1 X

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11546

11593

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span>			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b X <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4619 Highland Street</u>			d. STREET ADDRESS <u>4619 Highland Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>3. NAME OF DECEASED</b> (Type or print) <u>James Garrioch</u>			<b>4. DATE OF DEATH</b> Month <u>October</u> Day <u>15</u> Year <u>1959</u>		
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>April 7, 1865</u>		<b>9. AGE</b> (In years last birthday) <u>94</u> yrs.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Gardner</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Scotland</u>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>US</u>
<b>13. FATHER'S NAME</b> <u>Charles Garrioch</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Margaret Doldly</u>		
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> <u>Rebecca Garrioch-wife-same as 2d</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>400.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>					
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschart</u> M.D.			<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DATE SIGNED</b> <u>10/15/59</u>
<b>EXAMINER'S NAME (Type)</b> <u>Frank J. Broschart</u>			<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>10/17/59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Parklawn Cemetery</u>	
<b>22d. LOCATION (City, town, or county)</b> <u>Rockville, Maryland</u>		<b>22e. (State)</b>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey</u>			<b>ADDRESS</b> <u>Bethesda, Maryland</u>		<b>24a. REC'D BY REGISTRAR</b> DATE <u>OCT 16 '59</u>
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Rinaldi</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

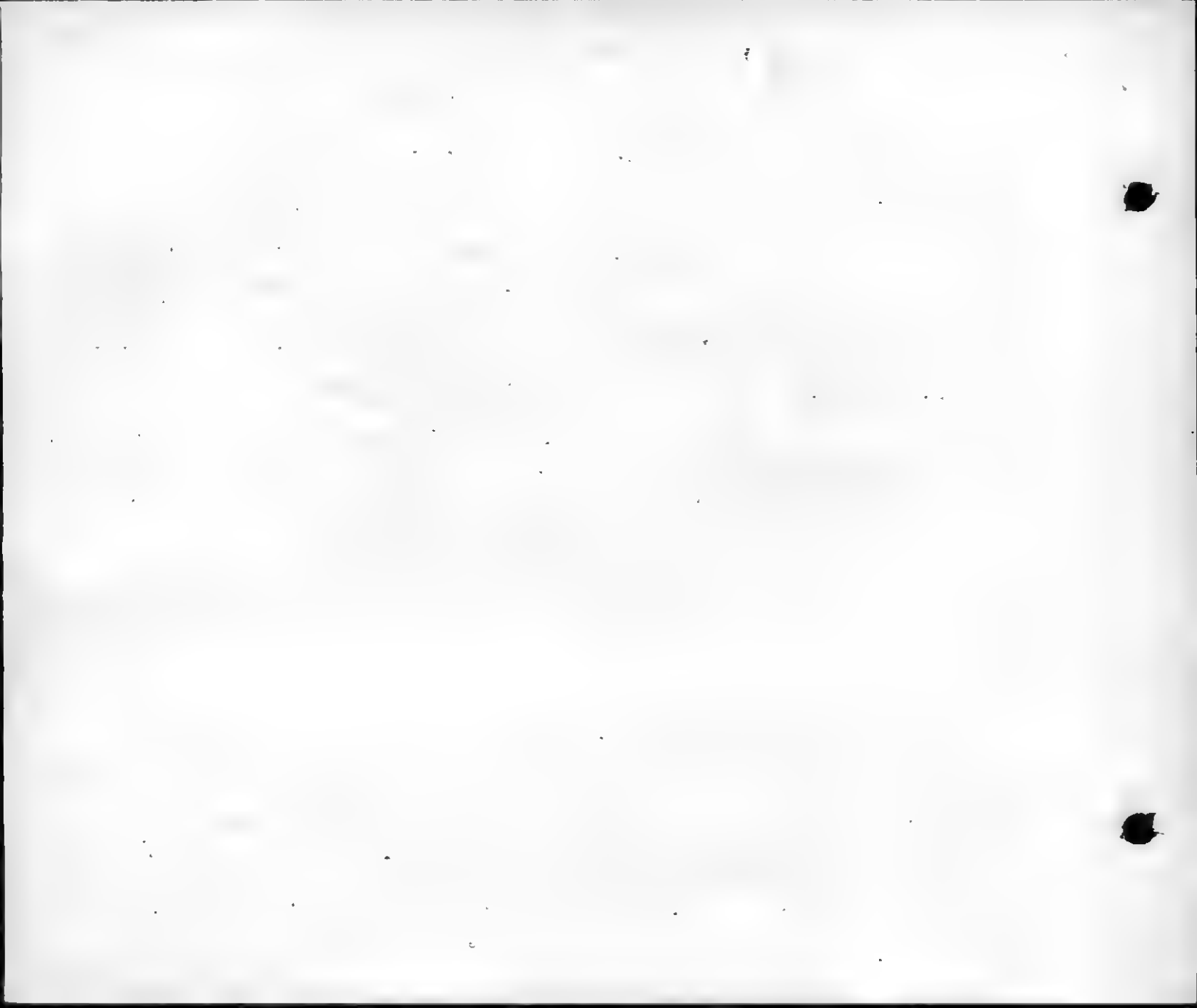
11547

11594

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4773 Bradley Blvd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ALMA</b> Middle <b>B.</b> Last <b>GATEWOOD</b>		4. DATE OF DEATH Month <b>October</b> Day <b>28</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 6, 1905</b>
9. AGE (In years last birthday) <b>54</b> yrs.		10. IF UNDER 1 YEAR Months <b>9</b> Days <b>22</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Leo F. Zwissler</b>		14. MOTHER'S MAIDEN NAME <b>Emma Schneider</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>W. Frank Gatewood - Husband - Item #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> <b>175.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Primary Carcinoma of OVARY</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6 Mo</b> <b>1 yr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct</b> , 1950, to <b>Oct</b> , 1959, that I last saw the deceased alive on <b>Oct 28</b> , 1959, and that death occurred at <b>8:57 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>2016 Georgetown Road</b> DATE SIGNED <b>Bethesda 14 Maryland</b>			
ACTUAL SIGNATURE <b>Leo I Donoivan M.D.</b>		M.D. <b>2016 Georgetown Road</b>	
PHYSICIAN'S NAME (Type) <b>LEO I DONOVAN M.D.</b>		Bethesda 14 Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-31-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 2 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>William S. Hines</b>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

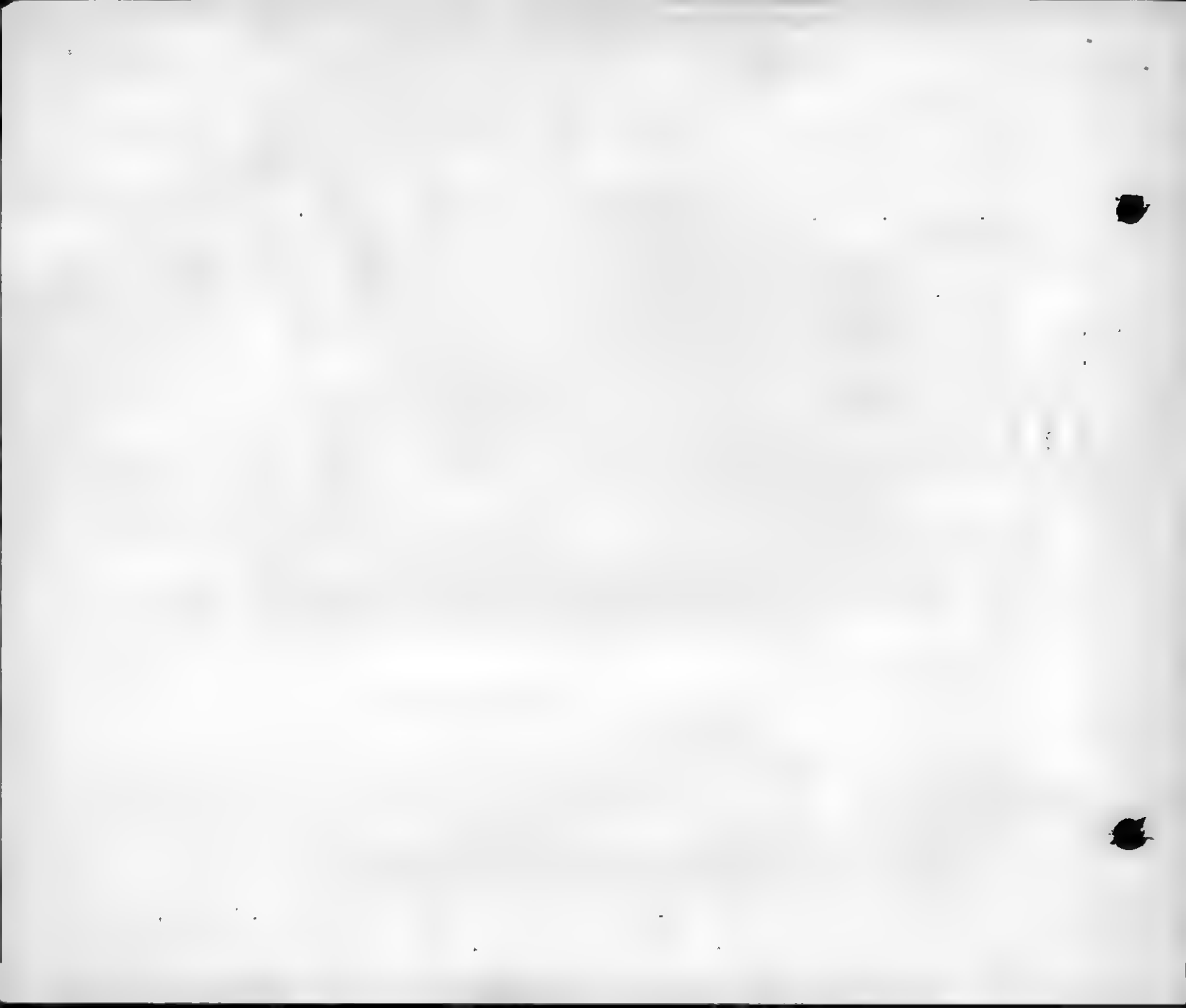
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11535

Reg. Dist. No. 11548

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton, Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>E. Montg. Ave. &amp; Bridge St.</u>			d. STREET ADDRESS <u>1708 Arcola Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>GEORGE RAYMOND GIBSON</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>5</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 31, 1885</u>	9. AGE (In years, last birthday) <u>74</u> yrs	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>			13. FATHER'S NAME <u>George Gibson</u>		
14. MOTHER'S MAIDEN NAME <u>Virginia Hinton</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>578-03-1063</u>			17. INFORMANT Address <u>Mrs Janie E. Gibson-Item# 2</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (a), stating the underlying cause lost. (c) <u>  </u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		10-5-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>10/8/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>		ADDRESS <u>WARNER E. PUMPHREY, INC. SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>DATE OCT 7 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the reason in the space provided. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Item 3 should be filed as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11509

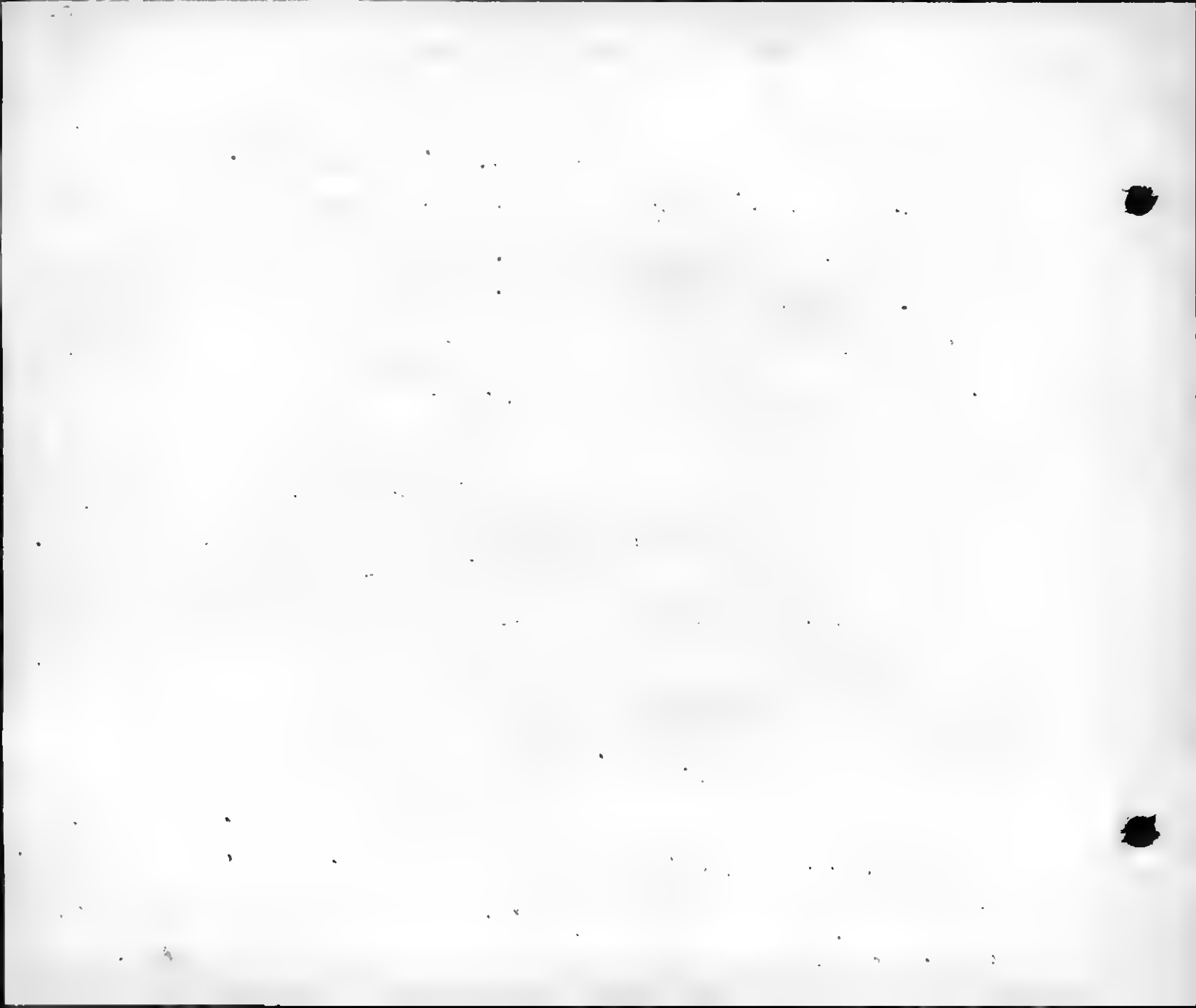
## CERTIFICATE OF DEATH

Reg. Dist. No. 11549

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>5 Silver Spring</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sant + Hospt.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Charlotte Beatrice Goodwin</i>		4. DATE OF DEATH Month Day Year <i>Oct. 24 1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-2-93</i>
9. AGE (In years last birthday) <i>65</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>N. Y.</i>		12. CITIZEN OF WHAT COUNTRY? <i>America</i>	
13. FATHER'S NAME <i>Philip Farron</i>		14. MOTHER'S MAIDEN NAME <i>Esther Abrams</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>—</i> INFORMANT Address <i>Patient's Chart.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Ventricular Fibrillation—Terminal</i> DUE TO (b) <i>Atherosclerotic Cardiovascular Disease</i> DUE TO (c) <i>with Congestive Heart Failure</i> INTERVAL BETWEEN ONSET AND DEATH <i>10 min</i> <i>about 4 years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes Mellitus</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>JUNE 1954</i> to <i>OCT 24 1959</i> that I last saw the deceased alive on <i>OCT 24 1959</i> , and that death occurred at <i>630 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>7733 ALASKA AVENUE NW WASH DC</i> DATE SIGNED <i>Oct 24 1959</i>			
ACTUAL SIGNATURE <i>Robert L. Krichmar</i> M.D.		PHYSICIAN'S NAME (Type) <i>Robert L. Krichmar M.D.</i>	
22a. BURIAL, CREMATON, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>OCT. 26, 1959</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>KILYB DAVID MEM. GARDEN</i>		22d. LOCATION (City, town, or county) (State) <i>FALLS CHURCH VA.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>B. Danyersky &amp; sons</i> ADDRESS <i>3501-14 St. N.W.</i>		24a. REC'D BY REGISTRAR DATE <i>OCT 28 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





11595

## CERTIFICATE OF DEATH

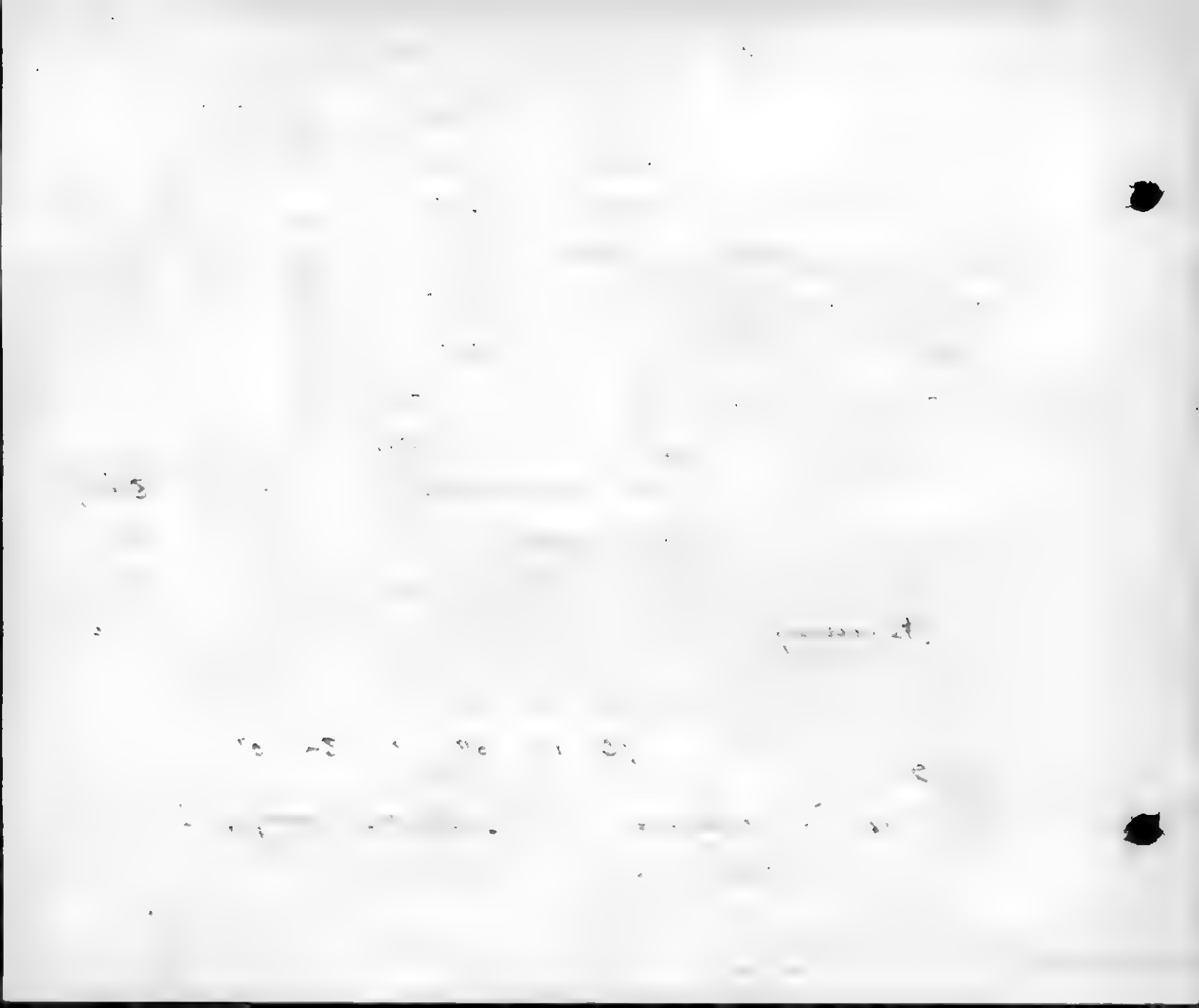
Reg. Dist. No.

11550

1 PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>				c. LENGTH OF STAY IN 1b <b>7 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY COUNTY GENERAL HOSPITAL</b>				/ d. STREET ADDRESS <b>Rt. #3</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOSEPH BRAKTON GRAY</b>				4. DATE OF DEATH Month Day Year <b>OCTOBER 8 19 59</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/10/71</b>	
9. AGE (In years last birthday) <b>88</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>				10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Bushrod Gray</b>				14. MOTHER'S MAIDEN NAME <b>Martha Kelly</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <b>INFORMANT</b>		Address <b>HOSPITAL RECORDS OLNEY, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BILATERAL BRONCHOPNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ACUTE TRACHEOBRONCHITIS</b> DUE TO (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility</b> INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b> <b>8 days</b> <b>years</b>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>10-1-1959</b> to <b>10-8-1959</b> , that I last saw the deceased alive on <b>OCT-7-1959</b> , and that death occurred at <b>2:30 A.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>W. C. Miller</b> M.D. <b>Gaithersburg, Md</b>							
ACTUAL SIGNATURE				PHYSICIAN'S NAME (Type) <b>W. C. MILLER, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>10-10-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Monocacy</b>	
22d. LOCATION (City, town, or county) (State) <b>Beallsville, Md.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest C. Gartner, Gaithersburg, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>OCT 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>William E. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11596

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>South Carolina</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>10 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jonesville</b>	
d. STREET ADDRESS <b>Route 1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Jean</b> Middle <b>Carroll</b> Last <b>Gregory</b>		4. DATE OF DEATH Month <b>October</b> Day <b>7</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 4, 1934</b>
9. AGE (In years last birthday) <b>25</b> yrs.		10. IF UNDER 1 YEAR Months <b>25</b> Days <b>25</b> Hours <b>25</b> Min.	
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>	
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Albert A. Gregory</b>		14. MOTHER'S MAIDEN NAME <b>Mattie Bailey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>Unascertainable</b>	
17. INFORMANT <b>The Medical Record, Address</b>		18. CITIZEN OF WHAT COUNTRY? <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Congenital heart disease</b> DUE TO <b>status, postoperative</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>Life</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>September 27 1959</b> to <b>October 7, 1959</b> , that I last saw the deceased alive on <b>October 7 1959</b> and that death occurred at <b>6:40 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center Bethesda 14, Maryland</b> DATE SIGNED <b>10/7/59</b>			
ACTUAL SIGNATURE <i>William W. Pfaff</i> M.D.		PHYSICIAN'S NAME (Type) <b>William W. Pfaff, M.D.</b>	
22a. DATE OF CREMATION, REMOVAL (Specify) <b>Burial - 10-7-59</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <b>Union, South Carolina</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Murphy</i>		24a. REC'D BY REGISTRAR <b>OCT 13 '59</b>	
ADDRESS <b>Bethesda, Md.</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Evans</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

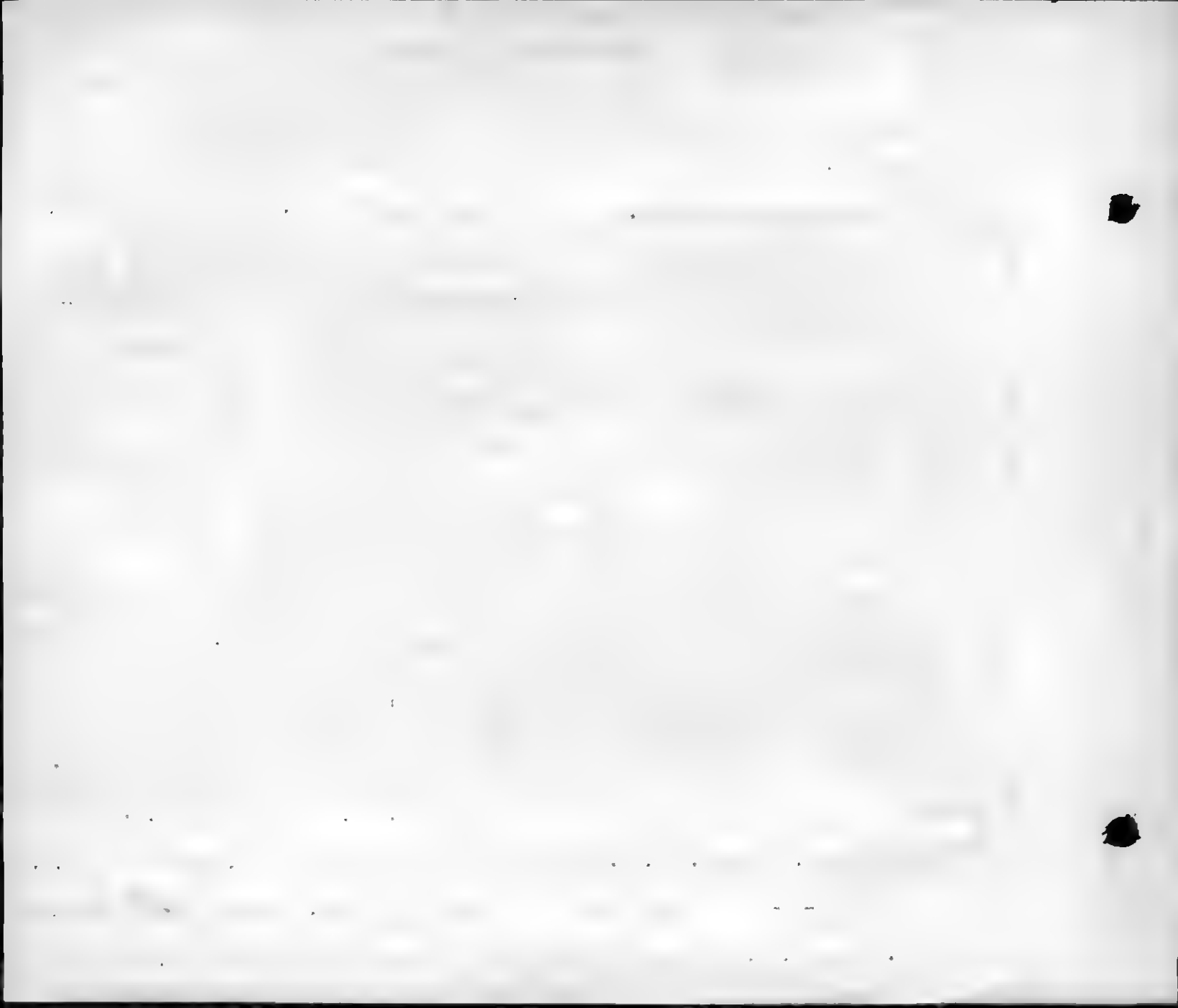


11510

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park,</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Sanitarium and Hosp.</b>				d. STREET ADDRESS <b>10427 Tullymore Dr.,</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Grguras</b>				4. DATE OF DEATH Month Day Year <b>October 11, 1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 10, 1959</b>		9. AGE (In years last birthday) yrs. <b>13</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <b>13 -</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>no</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>no</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>America</b>	
13. FATHER'S NAME <b>Adolf Rudolf Grguras</b>				14. MOTHER'S MAIDEN NAME <b>Shirley Marie Aiken</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>no</b>		17. INFORMANT <b>father</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> DUE TO <b>prematurity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							<b>13 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>Oct 11, 1959</b> to <b>Oct 11, 1959</b> that I last saw the deceased alive on <b>Oct 11, 1959</b> , and that death occurred at <b>4p</b> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>James D. Brew, Jr.</b> M.D. <b>1801 K St., N.W. Washington, D.C.</b>							
PHYSICIAN'S NAME (Type) <b>James D. Brew Jr., M.D.</b> <b>1801 K Street, N.W. Washington, D.C.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>10-12-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Washington Sanitarium &amp; Hospital, Takoma Park 12, Maryland</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Robert A. Hare, M. D. Washington Sanitarium and Hospital Takoma Park 12, Maryland</b>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11597

## CERTIFICATE OF DEATH

11553

Reg. Dist. No.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Laytonsville</b> b. COUNTY <b>Mont.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boys</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Maryland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Simpson Nursing Home</b>		d. STREET ADDRESS <b>1</b>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Waters</b> Last <b>Griffith</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>5</b> Year <b>1959</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 14, 1879</b>
9. AGE (In years last birthday) <b>80</b> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gen. Construction Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>William Riggs Griffith</b>		14. MOTHER'S MAIDEN NAME <b>Isabel Griffith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>Unknown</b>	
17. INFORMANT <b>Mrs. Jessie M. Griffith</b>		Address <b>Same as 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho pneumonia</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart disease with failure</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>20 days</b> <b>10 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3 Sept. 1959</b> to <b>5 Oct. 1959</b> , that I last saw the deceased alive on <b>5 Oct. 1959</b> , and that death occurred at <b>10:12</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Baynesville, Md. 5 Oct. 59</b>			
ACTUAL SIGNATURE <b>John M. Smith</b>		M.D.	
PHYSICIAN'S NAME (Type) <b>John M. Smith</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 8, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Laytonsville Meth.</b>		22d. LOCATION (City, town, or county) (State) <b>Laytonsville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Clayton Barber</b>		ADDRESS <b>Laytonsville, Md.</b>	
24a. RECORDING REGISTRAR'S SIGNATURE <b>Oct 9 1959</b>		24b. REGISTRAR'S SIGNATURE <b>Clayton Barber</b>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G254 1-20-60 et

11598

## CERTIFICATE OF DEATH

11554

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>4 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Montgomery County General Hospital, Inc.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Landover</b>	
f. STREET ADDRESS <b>The Oaks, Ardmore, R.F.D.</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lula</b> Middle <b>Elizabeth</b> Last <b>Grosvenor</b>		4. DATE OF DEATH Month <b>10</b> Day <b>2</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2.26.69/ 1879</b>
9. AGE (In years lost birthday) yrs <b>80</b>		IF UNDER 1 YEAR Months <b>2</b> Days <b>19</b> Hours <b>59</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Iowa</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>Stephen Pitts</b>		14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Sisson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) [If yes, give war or dates of service] <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Thrombosis</b> (c) <b>Carcinoma of Urinary Bladder</b> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchopneumonia</b> INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9-25-59</b> to <b>10-2-59</b> , that I last saw the deceased alive on <b>10-1-59</b> , and that death occurred at <b>4:05 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J. W. Bird</b>		DATE SIGNED <b>10/3/59</b>	
PHYSICIAN'S NAME (Type) <b>J. W. Bird, M. D.</b>		ADDRESS (Street, city or town, state) <b>Sandy Spring, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 5 59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>National Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Falls Church Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ray W. Barber</b>		ADDRESS <b>Laytonsville, Md</b>	
24a. REC'D BY REGISTRAR <b>OCT 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur J. Harris</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

11555

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Montg.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sandy Spring</b>		c. LENGTH OF STAY IN life <b>life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sandy Spring</b>	
3 NAME OF DECEASED (Type or print) <b>William Henry Hackett</b>		4. DATE OF DEATH <b>Oct. 26 1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 15, 1883</b>
9. AGE (In years, months, days, hours, min.) <b>76</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Houseman</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Anna Hackett</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Estelle Hackett, Sandy Spring, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>4201</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive C.R.D.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arthritis. Raynaud's Syndrome.</b>	
19. INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hour</b>		20. DATE <b>June 58</b>	
21. 1946		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>Nov. 25, 1946</b>		20d. INJURY OCCURRED <b>While at work</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 25, 1946</b> to <b>Oct. 26, 1959</b> , that I lost saw the deceased alive on <b>Oct. 24, 1959</b> and that death occurred at <b>2:15 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Webster Sewell</b> M.D.		ADDRESS (Street, city or town, state) <b>Norbeck Rt. 1 Silver Spring, Md.</b>	
DATE SIGNED <b>10/29</b>			
PHYSICIAN'S NAME (Type) <b>Webster Sewell</b>			
22a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/30/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ash Memorial,</b>	22d. LOCATION (City, town, or county) (State) <b>Sandy Spring, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden</b>		ADDRESS <b>Rockville, Md.</b>	
24a. REC'D BY REGISTRAR <b>NOV 2 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



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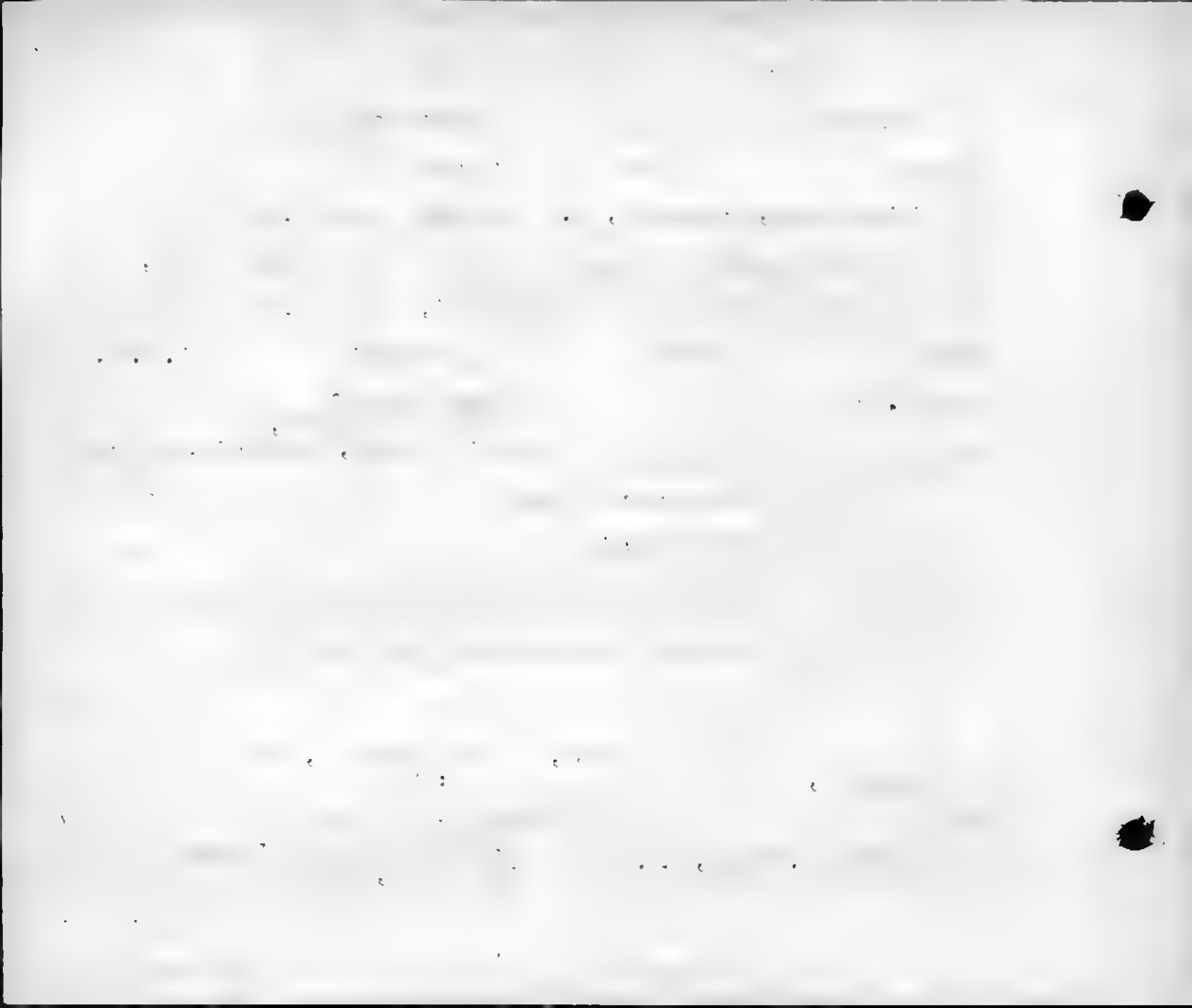
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Lancaster</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>84 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Harry</b> Last <b>Hall</b>				4. DATE OF DEATH Month <b>October</b> Day <b>2</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 4, 1948</b>	
9. AGE (In years last birthday) <b>10 yrs</b>		IF UNDER 1 YEAR IF UNDER 24 HRS		Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>							
13. FATHER'S NAME <b>Robert T. Hall</b>				14. MOTHER'S MAIDEN NAME <b>Esther Greenawalt</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>The Medical Record, The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhagic pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute Leukemia</b> DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>1 year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>July 10, 1959</b> to <b>October 2, 1959</b> , that I last saw the deceased alive on <b>October 2, 1959</b> , and that death occurred at <b>6:50 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Charles E. Mengel</b> M.D.				ADDRESS (Street, city or town, state) <b>The Clinical Center, Bethesda 14, Maryland</b>			
DATE SIGNED <b>10/2/59</b>							
PHYSICIAN'S NAME (Type) <b>Charles E. Mengel, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/5/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Strasburg Menno.Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Strasburg, Lanc.Co., Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ruth M. Young</b> ADDRESS <b>317 E. Orange St. Lancaster, Pa.</b>				24a. REC'D BY REGISTRAR <b>OCT 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kram</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



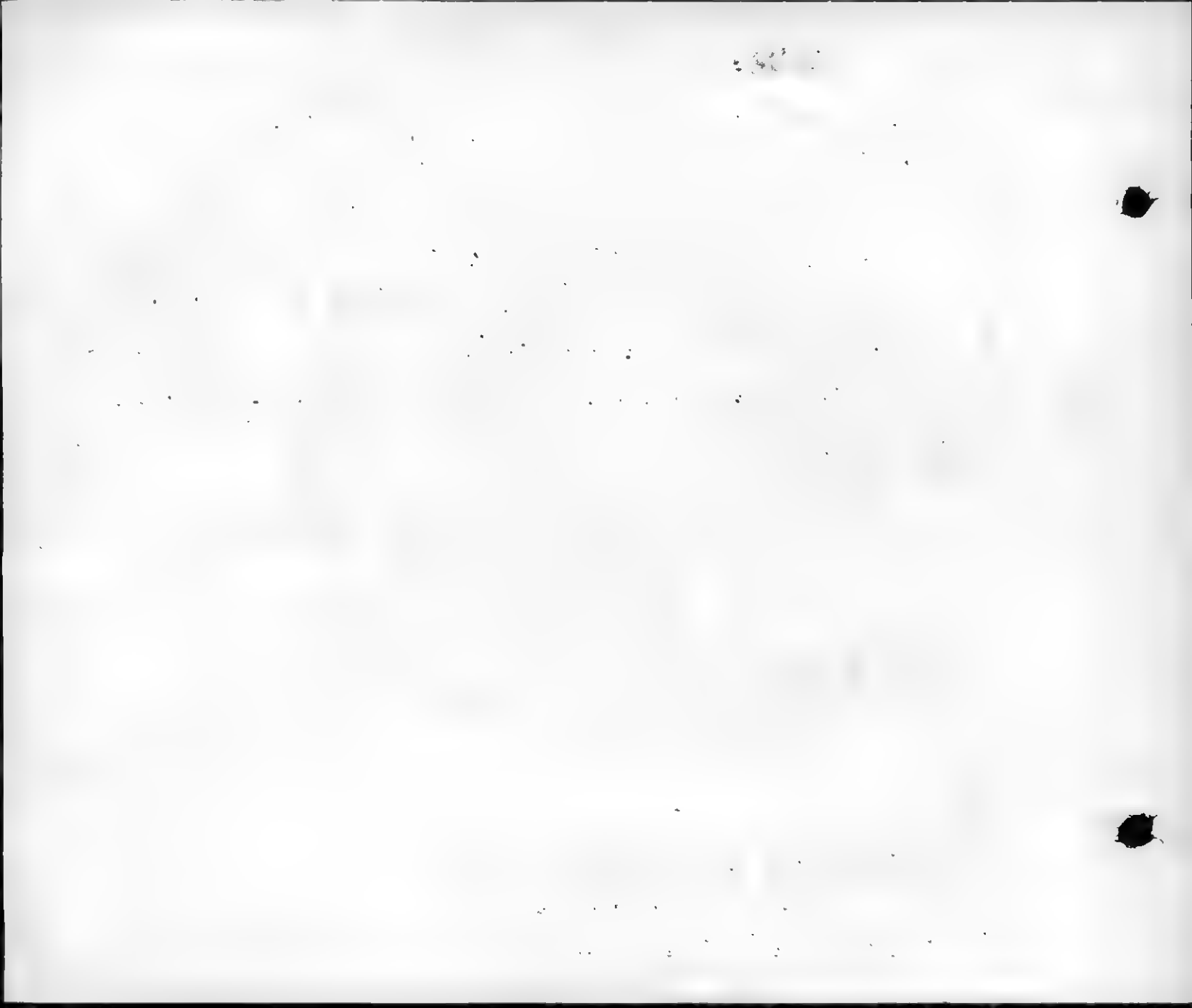
## CERTIFICATE OF DEATH

Reg. Dist. No.

11557

11601

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>26</u> <u>Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>1004 Lewis Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Ostrid</u> First <u>M. Hammarborg</u> Middle <u>M.</u> Last <u>Hammarborg</u>		4. DATE OF DEATH Month <u>10</u> Day <u>14</u> Year <u>1959</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 27, 1907</u>
9. AGE (In years last birthday) <u>52</u> yrs		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>17</u>	11. IF UNDER 24 HRS Hours <u></u> Min <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Research Analyst Nat'l Sec. Agency</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Illinois</u>	
10c. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Emil John Hammarborg</u>		14. MOTHER'S MAIDEN NAME <u>Auna Maria Norlin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>342-18-4188</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GENERALIZED CARCINOMATOSIS</u> DUE TO <u>151X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARCINOMA OF STOMACH-LIMITS PLASTIC</u> DUE TO <u>2 1/2 YRS</u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Brother - Frith of C. Hammarborg</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3/14/54</u> , 19 <u>54</u> , to <u>10/14/59</u> , that I last saw the deceased alive on <u>10/13, 1959</u> , and that death occurred at <u>2:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Florence E. Grady</u>		ADDRESS (Street, city or town, state) <u>1300-19-SX N.W. DC 6</u>	
PHYSICIAN'S NAME (Type) <u>FLORENCE E. GRADY</u>		DATE SIGNED <u>10/14/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-19-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		24a. REC'D BY REGISTRAR <u>16 '59</u>	
ADDRESS <u>Bethesda, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	





11558

11602

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE <b>MD</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>912 Heron Court (Private home)</b>		d. STREET ADDRESS <b>912 HERON COURT</b>	
3. NAME OF DECEASED (Type or print) First <b>Benjamin</b> Middle <b>George</b> Last <b>Hardy</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>23</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 29 1889</b>
9. AGE (In years last birthday) <b>70</b> yrs		IF UNDER 1 YEAR: IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BARBER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>North Carolina</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>PARROTT D. HARDY</b>		14. MOTHER'S MAIDEN NAME <b>SALOME Gaskill</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>	
17. INFORMANT <b>Cosae J Hardy 912 Heron Court</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Arteriosclerosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Myocardial Infarction 3 years</b> DUE TO (c) <b>Longstanding Renal Insufficiency</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 17, 1959</b> to <b>Oct. 23, 1959</b> that I last saw the deceased alive on <b>Sept 22, 1959</b> and that death occurred at <b>2:10 P.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>LYNWOOD HEIGES, M.D., F.A.C.A.</b> <b>10/23/59</b> <b>6940 Piney Branch Road, N.W.</b> <b>Washington 12, D.C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-26-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN</b>		22d. LOCATION (City, town, or county) (State) <b>BLADENSBURG MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Deal Funeral Home</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 27 '59</b>	
ADDRESS <b>4812 So Ann Ave</b>		24b. REGISTRAR'S SIGNATURE <b>Chilton S. Krawa</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 10/57



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11603

## CERTIFICATE OF DEATH

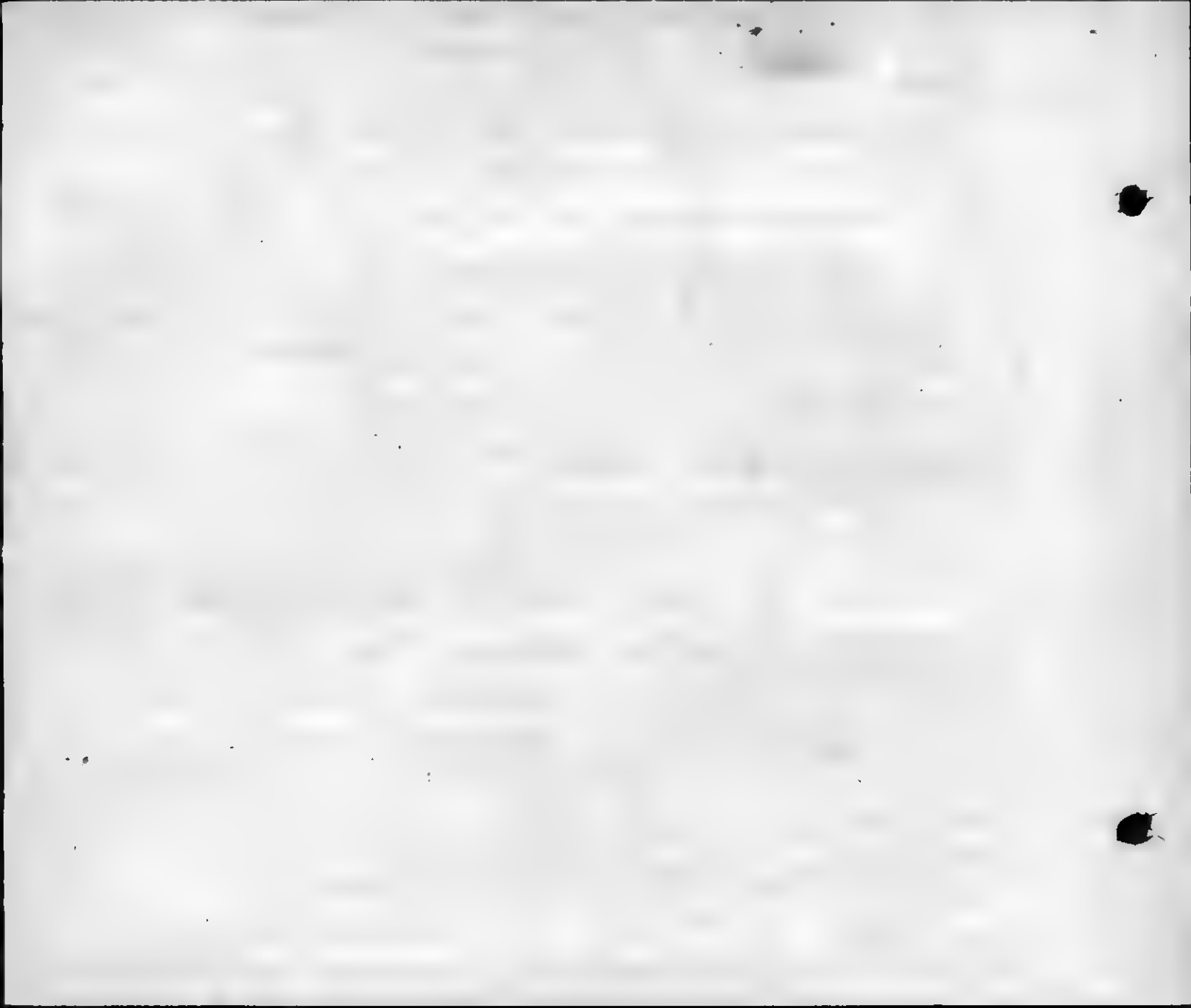
Reg. Dist. No.

11559

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>5 hrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>NELLY ELIZABETH HASLAM</b>		4. DATE OF DEATH <b>Oct. 18,</b> <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 16, 1879</b>
9. AGE (In years last birthday) <b>80</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Somerfield, New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Cromwell Haslam</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Worsley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>103-09-5351</b>	
17. INFORMANT <b>Lloyd P. Haslam-Item# 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Strangled by Umbilical Hernia with 560.2</b> DUE TO <b>1 foot of gangrenous ileum</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>1 foot of gangrenous ileum</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Arteriosclerosis</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 18, 1959</b> to <b>Oct. 18, 1959</b> , that I last saw the deceased alive on <b>Oct. 18, 1959</b> , and that death occurred at <b>10:45 M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Arthur F. Woodward</b> M.D.		ADDRESS (Street, city or town, state) <b>Rockville, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Arthur F. Woodward</b>		DATE SIGNED <b>10/19/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/21/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rockville Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler-1331 E. Montg. Ave.</b>		ADDRESS <b>Rockville, Md.</b>	
24a. REC'D BY REGISTRAR <b>OCT 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur F. Woodward</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for use in the burial, cremation, or removal, or in any event within 72 hours after death.



11536

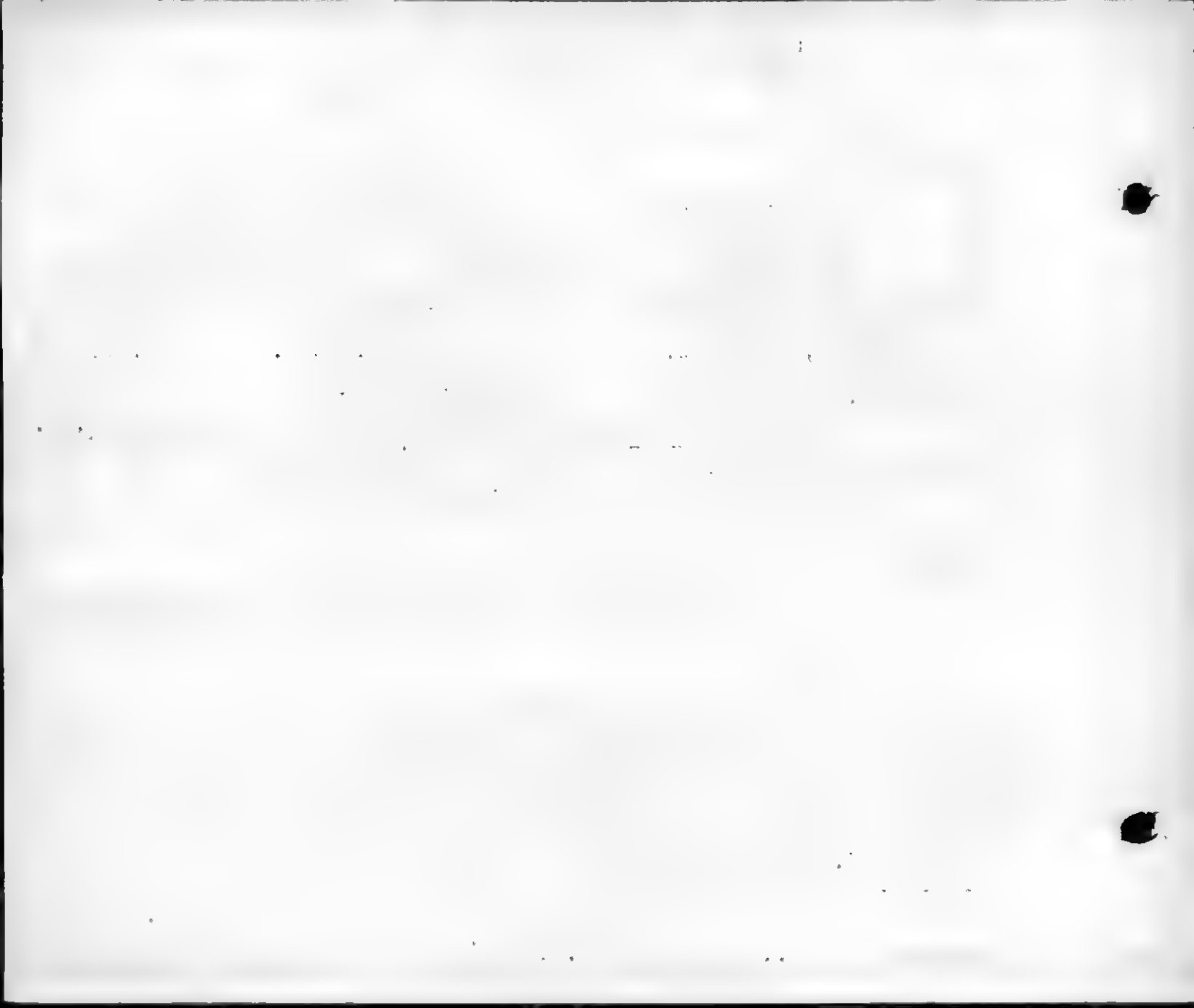
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1715 Henry Road</b>				d. STREET ADDRESS <b>1715 Henry Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>Hedderson</b> Last <b>Hedderson</b>				4. DATE OF DEATH Month <b>October</b> Day <b>25</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept 26, 1880</b>	
9. AGE (In years last birthday) <b>79</b> yrs		IF UNDER 1 YEAR Months <b>79</b> Days <b>79</b> Hours <b>79</b> Min <b>79</b>		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired fitter, Hecht Co.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>New London, Conn.</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Charles H. Mayer</b>				14. MOTHER'S MAIDEN NAME <b>Genevieve Herman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service.)				16. SOCIAL SECURITY NO <b>578-10-3728</b>			
INFORMANT <b>Elizabeth W. Hedderson</b>				Address <b>Rockville, Md. 1715 Henry Road,</b>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Vascular Disease</b> 422.1 DUE TO (b) <b>422.1</b> DUE TO (c) <b>422.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>0</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July 1, 1958</b> to <b>Oct. 25, 1959</b> that I last saw the deceased alive on <b>Oct. 25, 1959</b> and that death occurred at <b>10 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>J. Chester Brady</b> M.D.				ADDRESS (Street, city or town, state) <b>3524 Ave DNE</b>			
DATE SIGNED <b>10/25/59</b>							
PHYSICIAN'S NAME (Type) <b>J. Chester Brady</b>							
22a. DATE OF REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>10/28/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>New Haven, Conn.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co., 2901 14th St. N.W.</b>				24a. REC'D BY REGISTRAR <b>OCT 27 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11604

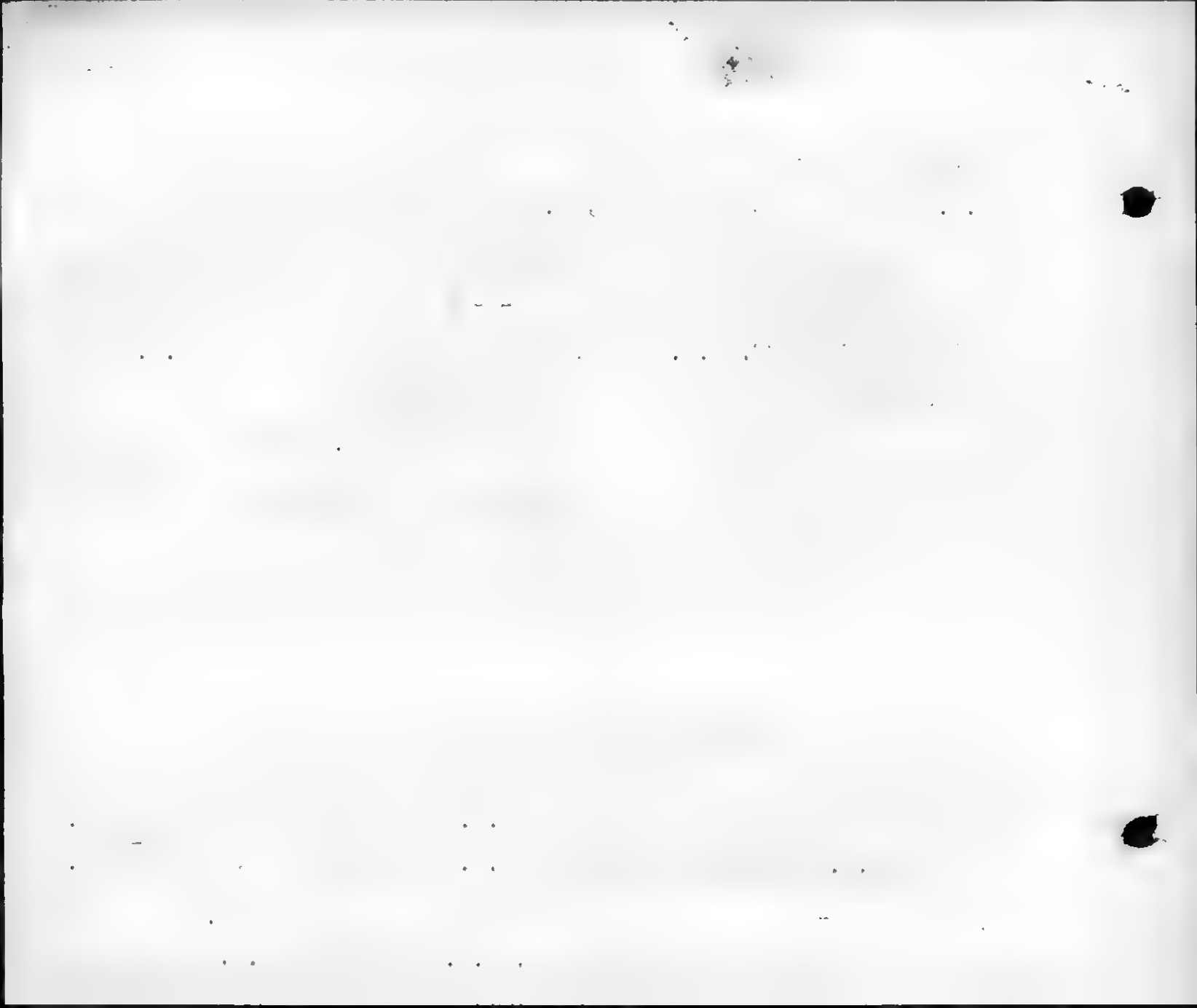
## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>29 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Virginia</b>		b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <b>302 East Broad Street</b>					
3. NAME OF DECEASED (Type or print) First Middle Last <b>Edward Pritz HERMAN</b>		4. DATE OF DEATH Month Day Year <b>October 7 1959</b>		5. SEX <b>Male</b>		6. CO. OR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>1-6-98</b>		9. AGE (In years last birthday) <b>61 yrs.</b>		10. UNDER 1 YEAR Months Days Hours Min. <b>61</b>		11. UNDER 24 HRS Months Days Hours Min. <b>61</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreign Service Off.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>		11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>William HERMAN</b>		14. MOTHER'S MAIDEN NAME <b>Belle PRITZ</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WWI &amp; II</b>		16. SOCIAL SECURITY NO. <b>(Wife) Annette C. HERMAN</b>		Address <b>Same as #2</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral, head of pressure - metastasis</b> DUE TO (b) <b>Cerebral, head of pressure - metastasis</b> DUE TO (c) <b>Cerebral, head of pressure - metastasis</b>		18. INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic cardiac muscular disease</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	
20f. (City or town) <b>Washington D.C.</b>		(County) <b>D.C.</b>		(State) <b>D.C.</b>		21. I certify that I attended the deceased from <b>8 September 59</b> to <b>7 October, 1959</b> that I last saw the deceased alive on <b>7 October 1959</b> , and that death occurred at <b>6:00 AM</b> , from the causes and on the date stated above		ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda Md.</b>	
21. ACTUAL SIGNATURE <b>D.P. OSBORNE CAPT MC USN</b>		21. DATE SIGNED <b>10-7-59</b>		22a. BURIAL, CREMATION REMOVAL (Specify) <b>Cremation 10-8-59</b>		22b. DATE THEREOF <b>10-8-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>	
22d. LOCATION (City, town, or county) <b>Suitland Md.</b>		(State) <b>D.C.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Gawlers &amp; Son</b>		24a. REC'D BY REGISTRAR <b>1756 Penn Ave. N.W.</b>		24b. REGISTRAR'S SIGNATURE <b>Washington D.C.</b>	

OCT 13 '59

Arthur J. Thomas





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 22b, Form 3-151 11/2/59.c

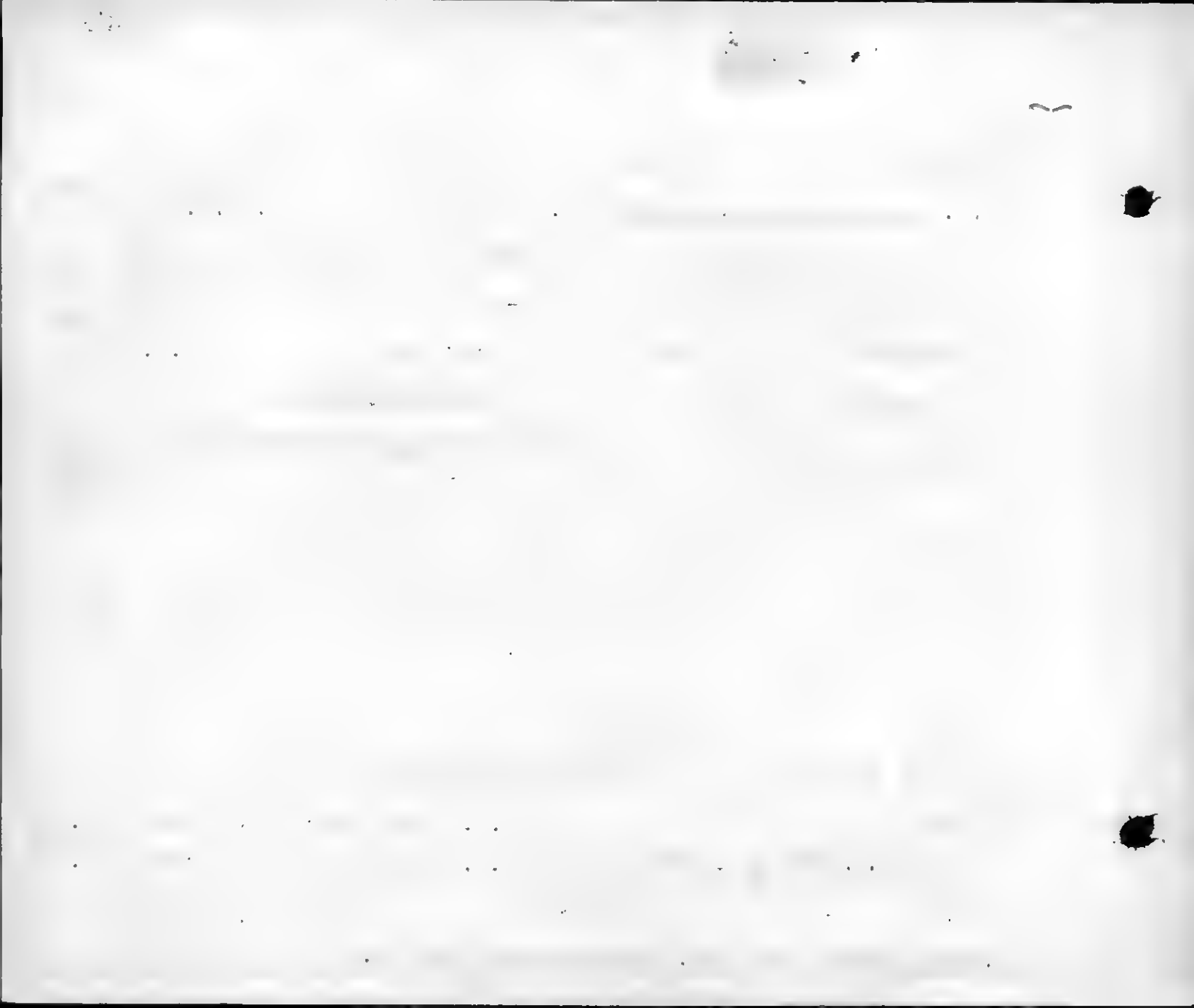
11562

11605

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>4 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>District of Columbia</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>3130 Wisconsin Ave. N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Florence Ruth HOBBS</b>		4. DATE OF DEATH Month Day Year <b>October 26 19 59</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>1-31-72</b>
9 AGE (In years last birthday) <b>87</b>		IF UNDER 1 YEAR Months Days Hours Min <b>87</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William GORE</b>		14. MOTHER'S MAIDEN NAME <b>Ruth STOCKSTALD</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO. <b>(Daughter) Mabel H ANDERSON Same as #2</b>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Congestive Heart Failure</b> DUE TO (b) <b>Extensive atherosclerotic Heart Disease</b> DUE TO (c) <b>Diabetes Mellitus</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>22 October 19 59</b> to <b>26 October 19 59</b> that I last saw the deceased alive on <b>26 October 19 59</b> and that death occurred at <b>3:35 PM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda Md.</b> ACTUAL SIGNATURE <b>R.G. Muth</b> M.D. <b>U.S. Naval Hospital, Bethesda Md.</b> PHYSICIAN'S NAME (Type) <b>R.G. MUTH LT MC USN</b> <b>U.S. Naval Hospital, Bethesda Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-28-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		22d. LOCATION (City, town or county) (State) <b>Pikesville, Maryland</b>	
23 FUNERAL DIRECTOR'S SIGNATURE <b>H. Sander and Sons North Ave. and Broadway Baltimore</b> <i>per Mr. Sander.</i>		24a. REC'D BY REGISTRAR <b>OCT 30 1959</b>	
24b. REGISTRAR'S SIGNATURE <i>Arthur L. Knepp</i>			



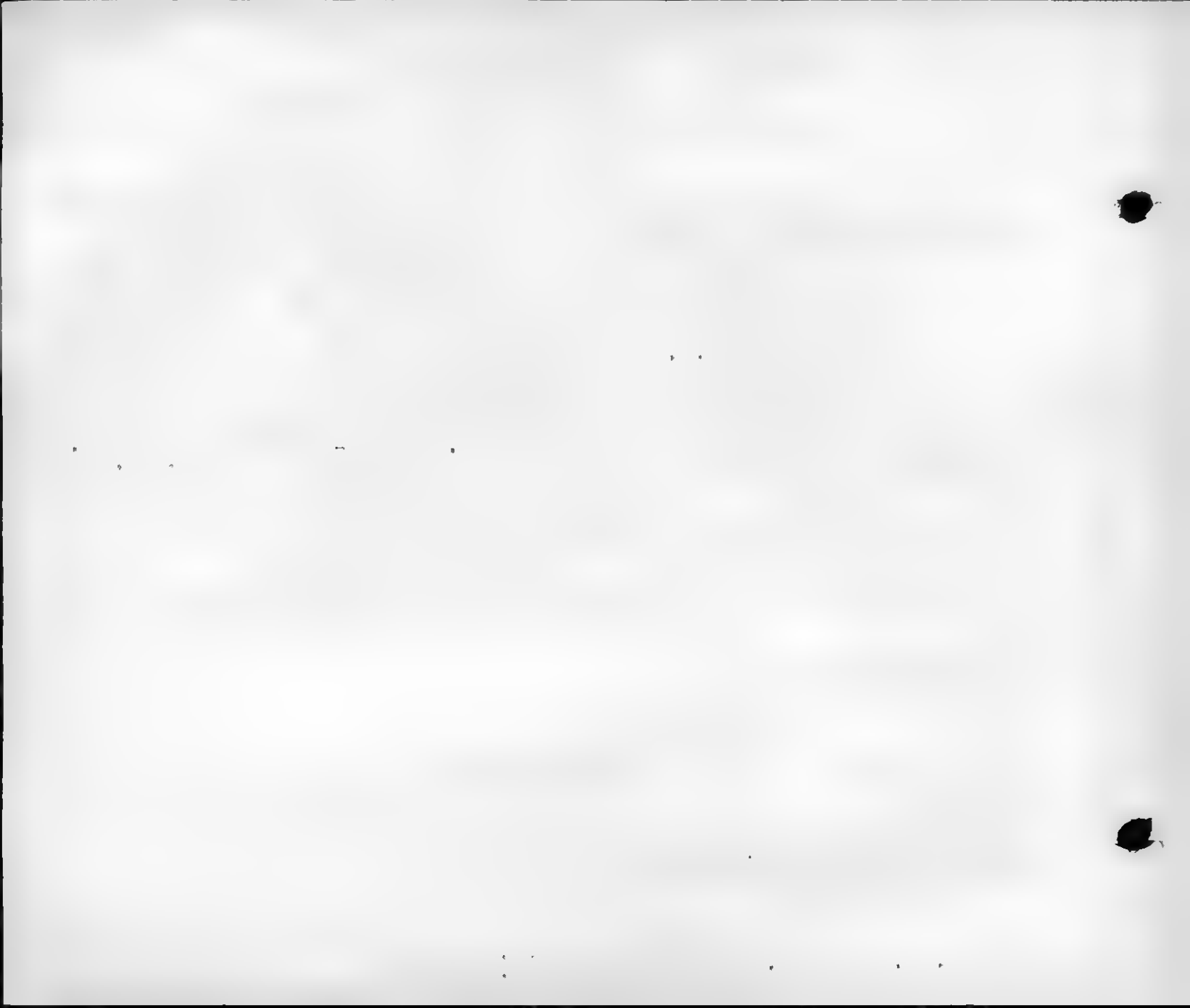
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>12 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sen v Hospital</u>		d. STREET ADDRESS <u>2307 Drexel St</u>	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Lyndon</u> Middle <u>Hobbs</u> Last		4. DATE OF DEATH Month <u>10</u> Day <u>31</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/30/1901</u>
9. AGE (In years last birthday) <u>58</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postal Supt.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Post Office</u>	
11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William E Hobbs.</u>		14. MOTHER'S MAIDEN NAME <u>Selena Lynn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Robert S. Purcell</u>		Address <u>2014 Ravenswood St. Hyattsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pneumonia</u> DUE TO <u>170</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Post acute Coronary Occlusion</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month _____ Day _____ Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>March</u> , 19 <u>52</u> , to <u>Oct 31</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct 31</u> , 19 <u>59</u> , and that death occurred at <u>1:31 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stewart Elchfield</u> M.D.		ADDRESS (Street, city or town, state) <u>6826 Riggs Rd Hyattsville, Md</u> DATE SIGNED <u>10/31/59</u>	
PHYSICIAN'S NAME (Type) <u>H. Wayne Elchfield</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/3/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Keedysville Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Keedysville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u>		ADDRESS <u>2901 14th St., N.W. Washington 9, D.C.</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

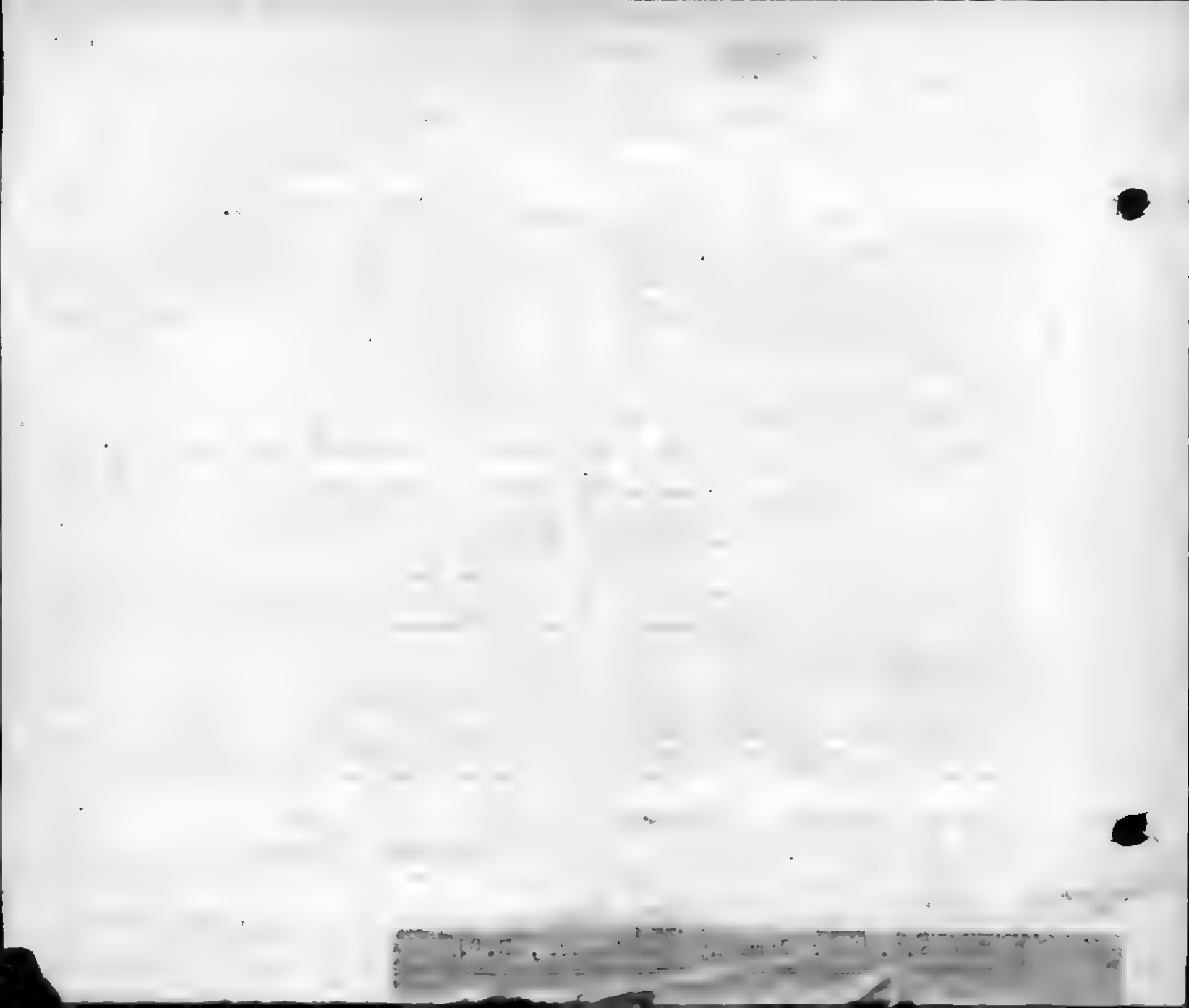
## 11606

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 11564

1. PLACE OF DEATH a. COUNTY <b>XXX Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 Silver Spring</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>735 Sligo Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Madge McCallum Hollingsworth</b>		4. DATE OF DEATH Month Day Year <b>OCTOBER 25 19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/6/1874</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Malcolm McCullum</b>		14. MOTHER'S MAIDEN NAME <b>Madora Geneva Wells</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Helen Hollingsworth</b>		Address <b>Silver Spring, 735 Sligo Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Gastrointestinal hemorrhage</b> DUE TO <b>Hepatic failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Biliary cirrhosis</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs</b> <b>1 month</b> <b>1 year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic cholelithiasis</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>7/21</b> , 19 <b>59</b> , to <b>10/25</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>10/24</b> , 19 <b>59</b> , and that death occurred at <b>11:30</b> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James R. Coleman MD</b>		ADDRESS (Street, city or town, state) <b>733 SLIGO AVE SILVER SPRING, MARYLAND</b>	
PHYSICIAN'S NAME (Type) <b>James R. Coleman</b>		DATE SIGNED <b>10/25/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>10/28/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>North Bend Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>North Bend, Pennsylvania</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Company</b>		24a. REC'D BY REGISTRAR <b>DATE OCT 27 '59</b>	
ADDRESS <b>Washington, D.C.</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Hines</b>	

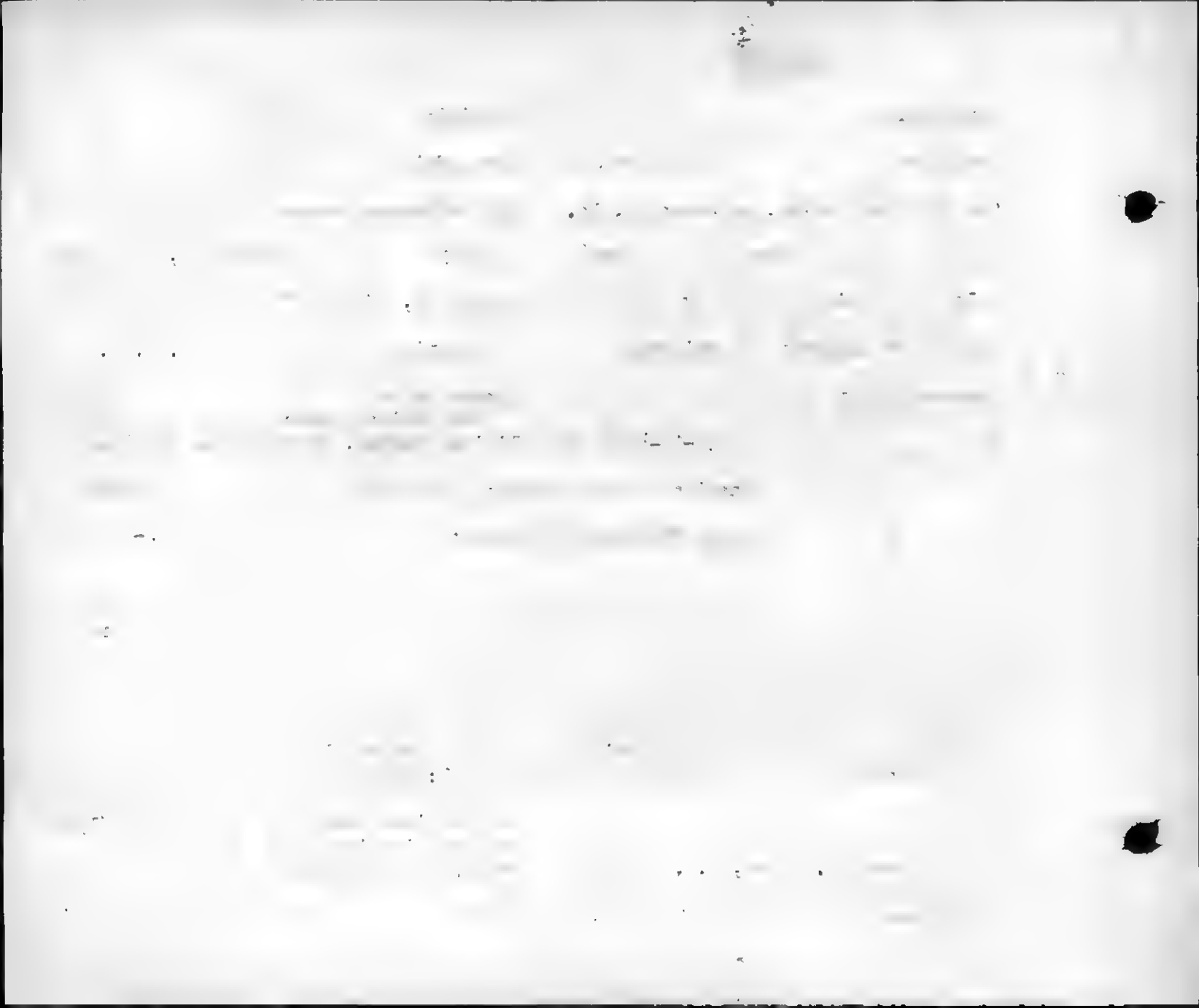


11607

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>173 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Alexandria</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>910 Jefferson Avenue</b> d. STREET ADDRESS <b>910 Jefferson Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>John</b>		First <b>John</b>		Middle <b>(None)</b>		Last <b>Holly</b>		4. DATE OF DEATH Month <b>October 14,</b> Day <b>1959</b> Year <b>1959</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 16, 1884</b>		9. AGE (in years last birthday) <b>75</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Locomotive Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Geremiah Holly</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Whitt</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>713-05-4754</b>		INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Massive Gastrointestinal Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Myelogenous Leukemia</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) _____								INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>2-3 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>April 24</b> , 19 <b>59</b> , to <b>October 14</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>October 14</b> , 19 <b>59</b> , and that death occurred at <b>1:40 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <b>10/15/59</b>									
ACTUAL SIGNATURE <b>Jerry S. Trier</b>				M.D. <b>The Clinical Center</b>					
PHYSICIAN'S NAME (Type) <b>Jerry S. Trier, M.D.</b>				National Institutes of Health <b>Bethesda 14, Maryland</b>					
22a. BURIAL, CREMATION REMOVAL (Specify) <b>Buried October 19, 59 Washington Park</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <b>INDIAN APOLIS INDIANA</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Nash &amp; Sons 714014 &amp; Son Nende, Va</b>				ADDRESS		24a. REC'D BY REGISTRAR <b>OCT 19 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Trier</b>	





11608

## CERTIFICATE OF DEATH

11566

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8661 11th Ave S. Spg.</u>		d. STREET ADDRESS <u>18661 11th Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>RIVA</u> Middle <u>G NAP</u> Last <u>HORIG</u>		4. DATE OF DEATH Month <u>10</u> Day <u>2</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>
9. AGE (In years last birthday) <u>76</u> yrs		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House doctor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Registered Alien</u>	
13. FATHER'S NAME <u>Graham</u>		14. MOTHER'S M maiden name <u>Libby</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> If yes, give war or date of service		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Miss Libby Davis</u>		Address <u>8661-11th Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause (b) <u>Congestive Heart Failure</u> lying cause (c) <u>ARTERIO SCLEROTIC HEART DISEASE</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 Hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1955</u> to <u>Oct. 2</u> , 1959, that I last saw the deceased alive on <u>Oct. 2</u> , 1959, and that death occurred at <u>1:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Max G. Sherer</u> M.D.		ADDRESS (Street, city or town, state) <u>7311 Colston Dr.</u> DATE SIGNED <u>10/2-59</u>	
PHYSICIAN'S NAME (Type) <u>MAX G. SHERER, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/2-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Nat Capital Heb Ceme</u>	22d. LOCATION (City, town, or county) (State) <u>Wash DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home</u> ADDRESS <u>Wash DC</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 6 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11609

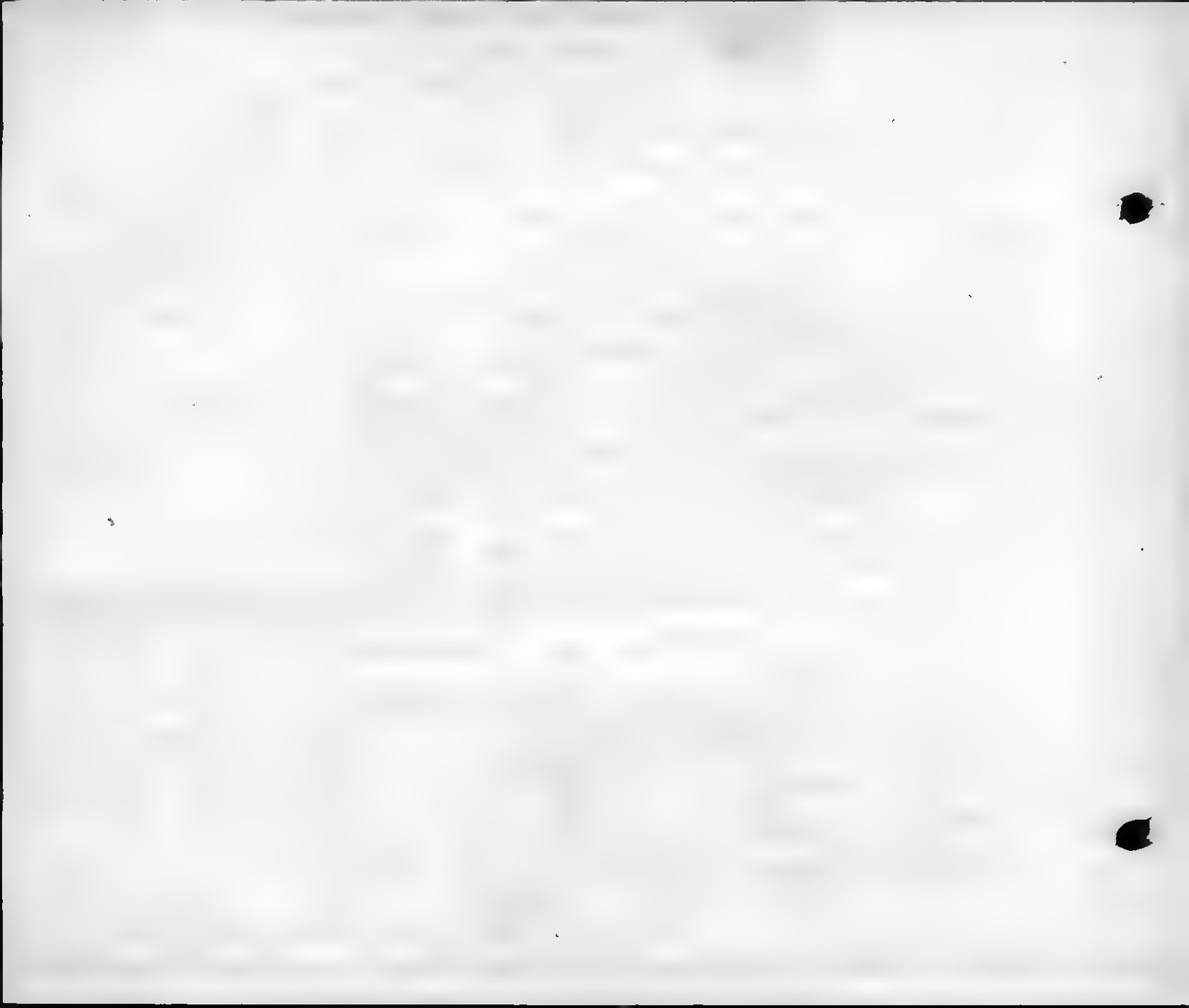
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VA.</u> b. COUNTY <u>WEST MORELAND</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FAITHERSBURG</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COLONIAL BEACH</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>REST HAVEN SANITORIUM</u>				d. STREET ADDRESS _____			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>V.</u> Last <u>HOY Sr.</u>				4. DATE OF DEATH Month <u>10</u> Day <u>21</u> Year <u>1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-1-81</u>	9. AGE (In years lost birthday) <u>78</u> yrs	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>PAINTER</u>		11. BIRTHPLACE (State or foreign country) <u>VA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>PETER HOY</u>			
14. MOTHER'S MAIDEN NAME <u>AMELIA TRAVERS</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>225-16-1627</u>				17. INFORMANT Address <u>BETHESDA, MD.</u> <u>MRS. MARY WATSON-9917 OLD GEORGETOWN ROAD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u>						<u>ONE WEEK</u>	
X DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIAL HYPERTENSION</u>						<u>20 YEARS</u>	
DUE TO (c) <u>ARTERIOSCLEROSIS</u>						<u>20 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS - UREMIA</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <u>September 18, 1958</u> , to <u>October 21, 1959</u> , that I last saw the deceased alive on <u>October 20, 1959</u> , and that death occurred at <u>4:10A M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John H. Rosenberg</u>				ADDRESS (Street, city or town, state) <u>26 N. SUMMIT AVE.</u> DATE SIGNED <u>OCT 21 1959</u>			
PHYSICIAN'S NAME (Type) <u>FAITHERSBURG, MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10-23-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wm. Oliver Cemetery</u>		22d. LOCATION (City, town, or county) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Collins</u> ADDRESS <u>3821-14th St. N.W.</u>				24a. REC'D BY REGISTRAR <u>DATE OCT 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>E. E. Knecht</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11610

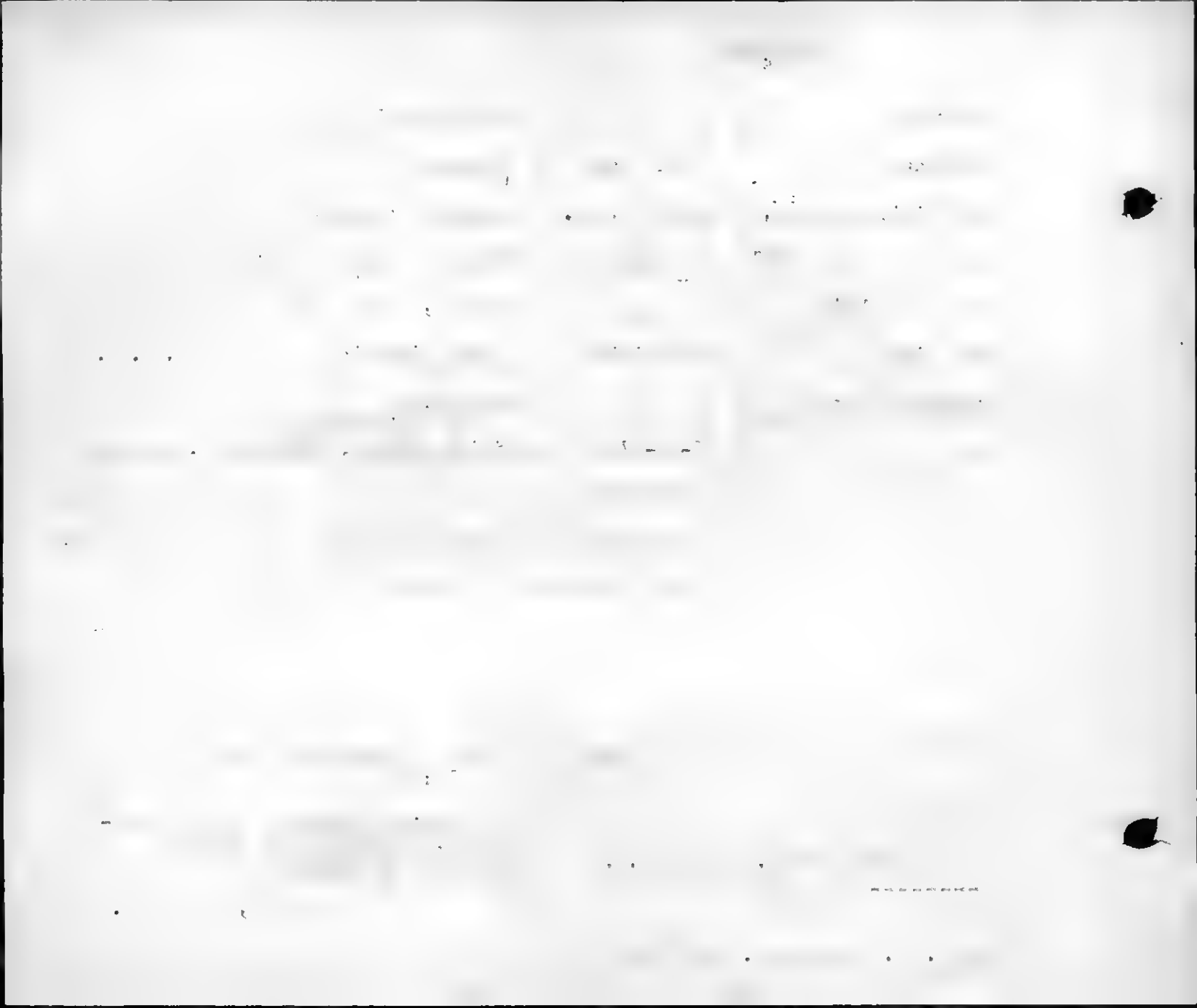
## CERTIFICATE OF DEATH

11568

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b>				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY <b>West Virginia</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverside</b>			
c. LENGTH OF STAY IN 1b <b>126 days</b>				d. STREET ADDRESS <b>No street address</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Carl</b>		Middle <b>Edward</b>		Last <b>Hudnall</b>		4. DATE OF DEATH Month <b>October</b> Day <b>26</b> Year <b>1959</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 9, 1929</b>	
9. AGE (in years last birthday) <b>30</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Coal Miner</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Lawrence Hudnall</b>				14. MOTHER'S MAIDEN NAME <b>Vada Walker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>233-44-0799</b>		INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Septicemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Necrotizing, ulcerative colitis</b> DUE TO (c) <b>Acute lymphocytic leukemia</b>							INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>  <b>unknown</b>  <b>1 year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 22, 1959</b> to <b>October 26, 1959</b> , that I last saw the deceased alive on <b>October 26, 1959</b> , and that death occurred at <b>11:45 A.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>10-26-59</b>							
ACTUAL SIGNATURE <b>Lawrence A. Gaydos</b>		M.D. <b>The Clinical Center</b>					
PHYSICIAN'S NAME (Type) <b>Lawrence A. Gaydos, M.D.</b>		<b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>					
22a. <del>DATE OF REMOVAL</del> (Specify) <b>Removal</b>		22b. DATE THEREOF <b>10/27/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Charleston, West, Va.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Co. Washington, DC</b>				24a. REC'D BY REGISTRAR DATE <b>OCT 28 '59</b>		24b. REGISTRAR'S SIGNATURE <b>William S. Turner</b>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11569

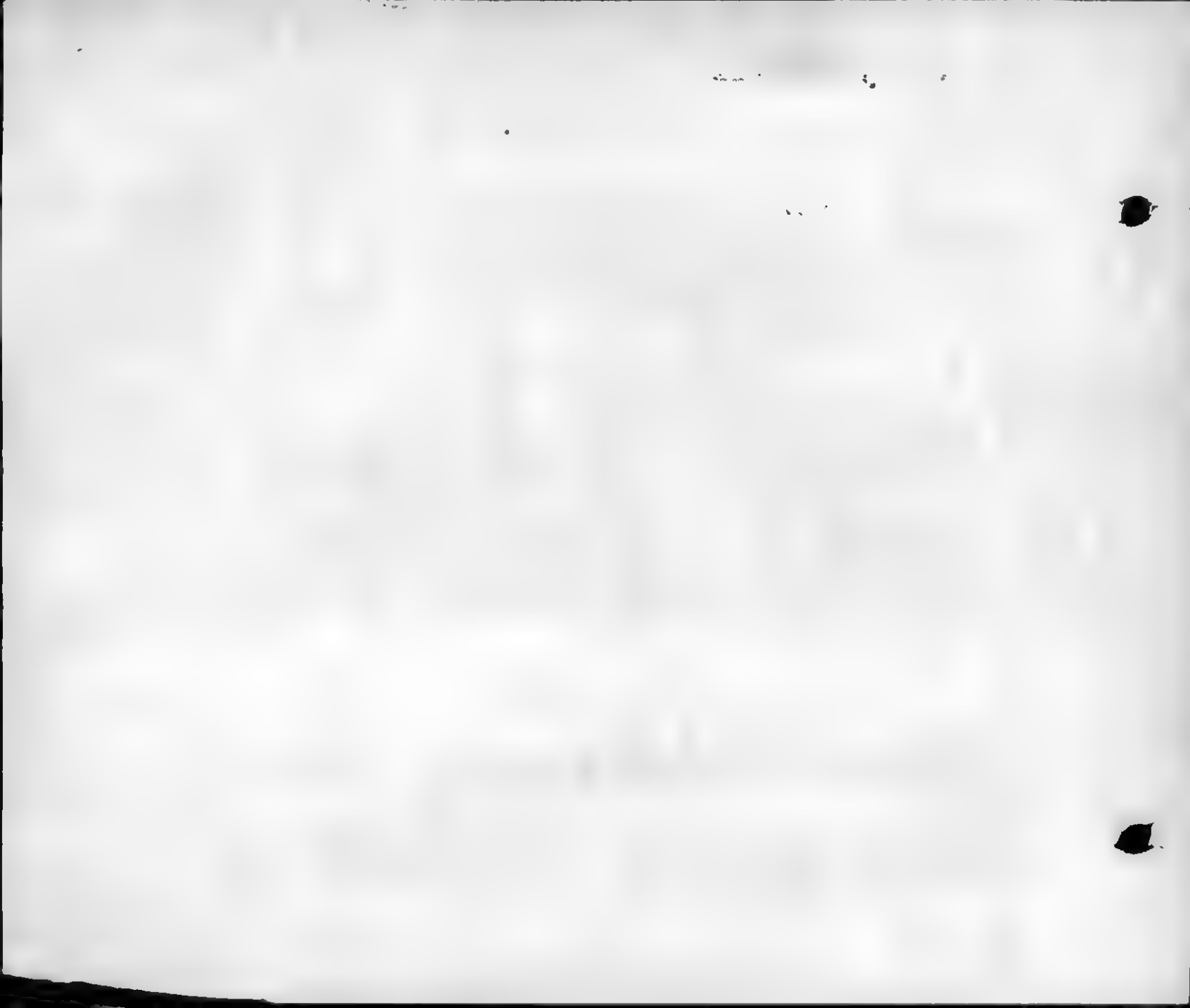
11611

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P. G.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN TB <u>5 hrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. STREET ADDRESS <u>6410 Greig Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Roy</u> Middle <u>Lee</u> Last <u>Hughes</u>		4. DATE OF DEATH Month <u>10</u> - Day <u>22</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 26 1904</u>
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Julius Hughes</u>		14. MOTHER'S MAIDEN NAME <u>Murdock</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Mary Lucille Hughes - Wife</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terrmination of Brain stem</u> 901.6 DUE TO <u>Intracranial Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (b) <u>Cerebral Contusions and Fractures</u> (c) <u>  </u> DUE TO <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fractured skull</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 hours</u> <u>5 hours</u> <u>5 hours</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall from scaffold while working on construction job</u>	
20c. TIME OF INJURY Month, Day, Year <u>12-15 10-22 1959</u>	20d. INJURY OCCURRED While of work <input checked="" type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>bed.</u>	20f. (City or town) <u>Silver Spring Montg Md</u> (County) <u>  </u> (State) <u>  </u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>10-23-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-26-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>F-T Lincoln Cem</u>	22d. LOCATION (City, town, or county) <u>Bladensburg Md</u> (State) <u>  </u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers</u>		24a. REC'D BY REGISTRAR <u>  </u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>
ADDRESS <u>5801 Cleveland Ave</u>		DATE <u>OCT 26 '59</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. The Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



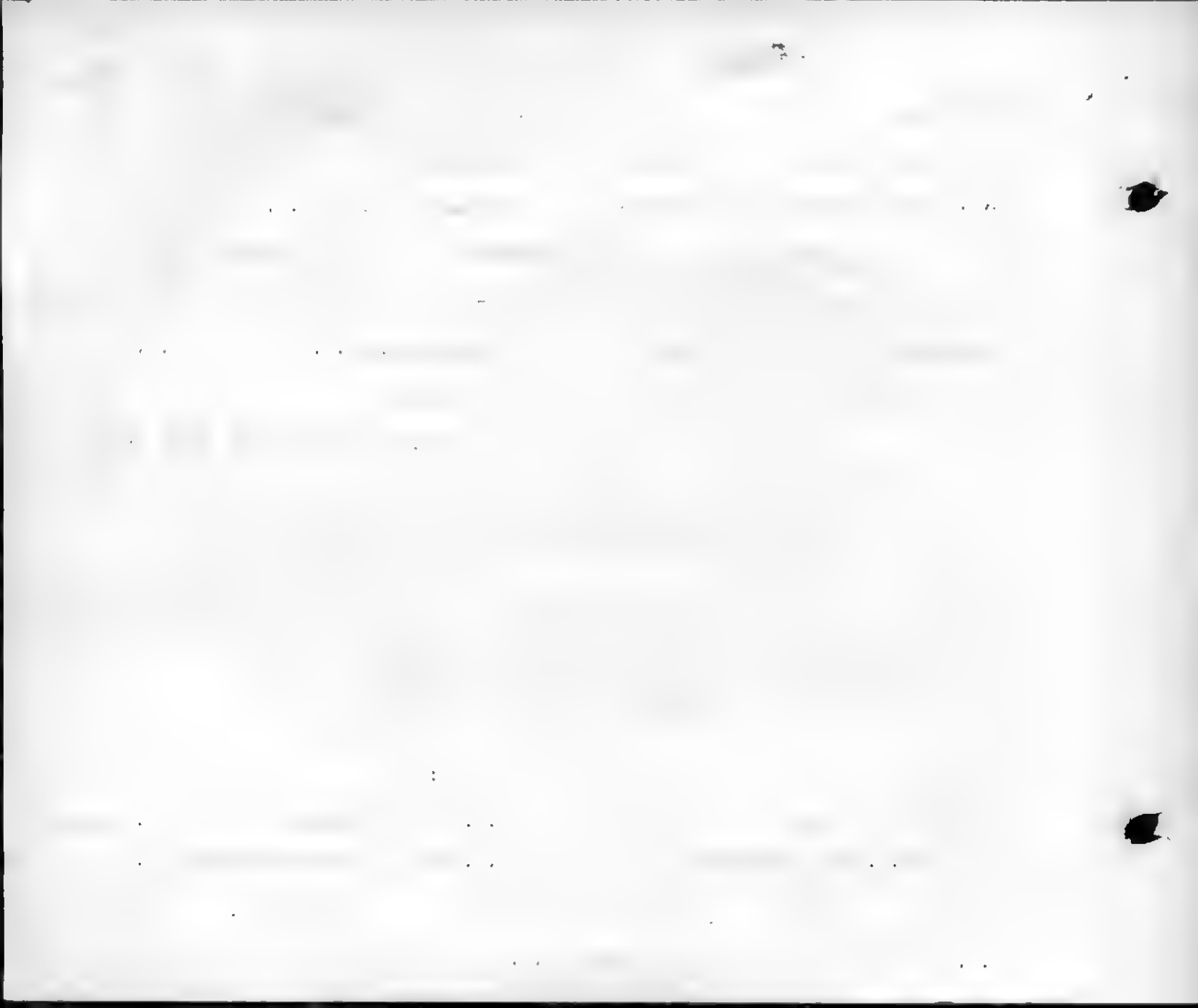


11612

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1 PLACE OF DEATH a COUNTY <b>Montgomery</b> b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c LENGTH OF STAY IN 1b <b>49 days</b> d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE <b>District of Columbia</b> b COUNTY <b>Washington</b> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d STREET ADDRESS <b>127 Varnum Street N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Norma Mae HUNTER</b>		4. DATE OF DEATH Month Day Year <b>October 30 19 59</b>	
5. SEX <b>Female</b>	6 COLOR OR RACE <b>Negro</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-15-37</b>
9. AGE (In years last birthday) <b>22 yrs</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	11 BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>
10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Sidney JOHNSON</b>		14. MOTHER'S MAIDEN NAME <b>Sara HACKETT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO. <b>INFORMANT</b> <b>(Husband) Eccleseastes Hunter Same as #2</b>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>416x</b> DUE TO <b>Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Rheumatic Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1612</b>		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11 September 1959</b> to <b>30 October 1959</b> , that I last saw the deceased alive on <b>30 October 1959</b> , and that death occurred at <b>8:15 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda Md. 10-31-59</b>			
ACTUAL SIGNATURE <b>R. G. Muth</b>		M.D. <b>U.S. Naval Hospital, Bethesda Md. 10-31-59</b>	
PHYSICIAN'S NAME (Type) <b>R.G. MUTH LT MCUSN</b>		<b>U.S. Naval Hospital, Bethesda Md.</b>	
22a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-3-59</b>	22c NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d LOCATION (City, town, or county) (State) <b>Arlington Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.E. Jarvis 1432 U Street Washington, D.C.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 3 1959</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 11613 Item 14 11-2-59 et  
 CERTIFICATE OF DEATH

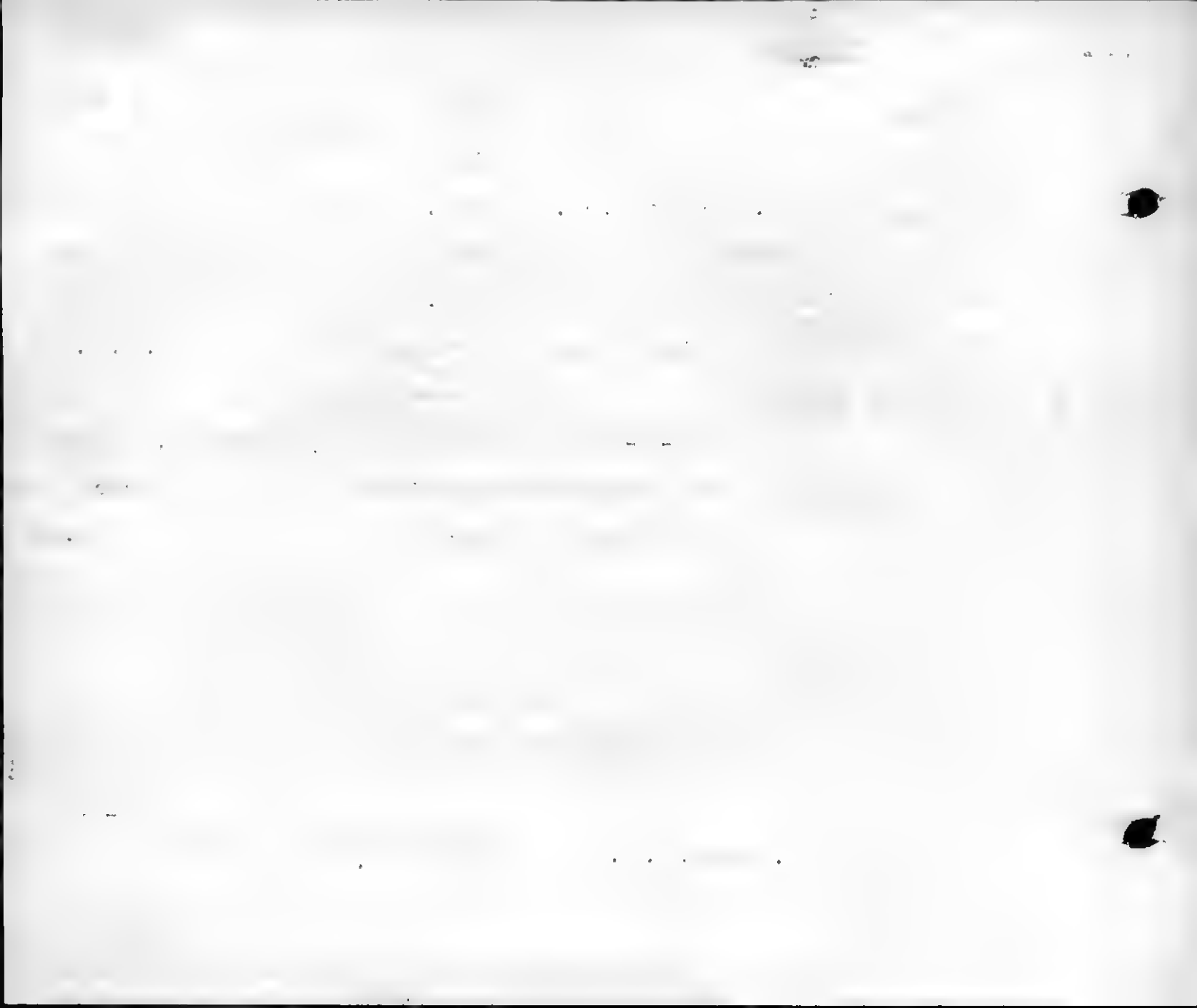
11571

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>8 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>4</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hialeah</b> d. STREET ADDRESS <b>348 W. 64th Terrace</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>FLOYD</b> Last <b>HUNTLEY</b>				4. DATE OF DEATH Month <b>October</b> Day <b>31</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 12, 1936</b>	
9. AGE (in years last birthday) <b>23</b> yrs		10. IF UNDER 1 YEAR Months <b>23</b> Days <b>23</b> Hours <b>23</b> Min <b>23</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sheet Metal Worker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Sheet Metal</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>	
13. FATHER'S NAME <b>Lee William Huntley</b>				14. MOTHER'S MAIDEN NAME <b>Hazel DeHooq Tuttle</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>267-46-5790</b>		INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute gastrointestinal hemorrhage</b> 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute lymphocytic leukemia</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>10 months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 23, 1959</b> to <b>October 31, 1959</b> , that I last saw the deceased alive on <b>October 31, 1959</b> , and that death occurred at <b>11:45 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>11-1-59</b>							
ACTUAL SIGNATURE <b>Charles E. Mengel</b> M.D.				NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) <b>Charles E. Mengel, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>SHIP RR</b>		<b>11-2-59</b>		<b>H</b>		<b>HIALEAH, FLA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers</b>				ADDRESS <b>1400 Chapin St NW</b>		24a. REC'D BY REGISTRAR <b>NOV 3 '59</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kross</b>	

2

1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

Dr. Broshart - County Coroner was contacted

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11512

## CERTIFICATE OF DEATH

11572

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN TB <u>DOA</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clifford Warren Hurley</u>				4. DATE OF DEATH Month Day Year <u>10 7 1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-24-92</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Aero. Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Navy Dept.</u>		11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Samuel Hurley</u>				14. MOTHER'S M maiden NAME <u>Lottie Chase</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs Mildred R Hurley</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MASSIVE Retroperitoneal Hemorrhage</u> <u>451X</u> DUE TO <u>Rupture Arteriosclerotic Aneurysm Abdominal Aorta</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/12</u> 19 <u>47</u> , to <u>10/7</u> 19 <u>59</u> , that I last saw the deceased alive on <u>10/7</u> 19 <u>59</u> , and that death occurred at <u>1:10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dean H Harding</u> M.D.				ADDRESS (Street, city or town, state) <u>113 Carroll St NE</u> DATE SIGNED <u>10/7/59</u>			
PHYSICIAN'S NAME (Type) <u>DEAN H. HARDING</u>				<u>Wash DC</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. &amp; BURIAL</u>		22b. DATE THEREOF <u>10/9/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Elmira, New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Liska</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 9 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Colin R. K...</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please state the cause, date, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 to the coroner. Give Page 5 to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11614

Reg. Dist. No.

11573

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Virginia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>7 hrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5100 River Rd.</b>		d. STREET ADDRESS <b>3521 Wilson Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>Claude Charles Hustwayte</b>		4. DATE OF DEATH Month <b>Oct</b> Day <b>16</b> Year <b>19 59</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-8-92</b>
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nightwatchman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wash. Petro. Prod.</b>	
11. BIRTHPLACE (State or foreign country) <b>Florida</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Claude C. Hustwayte</b>		14. MOTHER'S MAIDEN NAME <b>Mae Reddish</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-07-4635</b>	
17. INFORMANT <b>Violet Hustwayte-wife-same as 2d</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage and Lacerations</b> <b>7/16 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>XX Bullet Wound Thru Skull</b> (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Self inflicted bullet wound thru skull</b>	
20c. TIME OF INJURY Month, Day, Year <b>? 10-16 1959</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Office Bldg.</b>		20f. (City or town) (County) (State) <b>Bethesda, Montg., Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		October 16, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/19/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Bladensburg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>OCT 19 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	





TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11615

## CERTIFICATE OF DEATH

11574

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooksville</u>		c. LENGTH OF STAY IN 1b <u>2 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>"Greystone", Rt 1.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles Morris Irelan</u>		4. DATE OF DEATH Month <u>10</u> Day <u>30</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUN 8, 1905</u>
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Genl. Council</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>M.N.C.P.P.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>Dist. of Cal.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles Morris Irelan</u>		14. MOTHER'S MAIDEN NAME <u>Francis White</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, never unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>Julia M. Irelan</u> Address <u>Brooksville, Md (wife)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>Arterio sclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>3 yrs</u> (c)			INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 10/30</u> , 19 <u>59</u> , to <u>10/30</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10/30</u> , 19 <u>59</u> , and that death occurred at <u>7:15 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. H. L. Irelan</u>		ADDRESS (Street, city or town, state) <u>Sandy Spring, Md</u> DATE SIGNED <u>10/30/59</u>	
PHYSICIAN'S NAME (Type) <u>C. H. L. Irelan</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11/2/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 3 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11575

11616

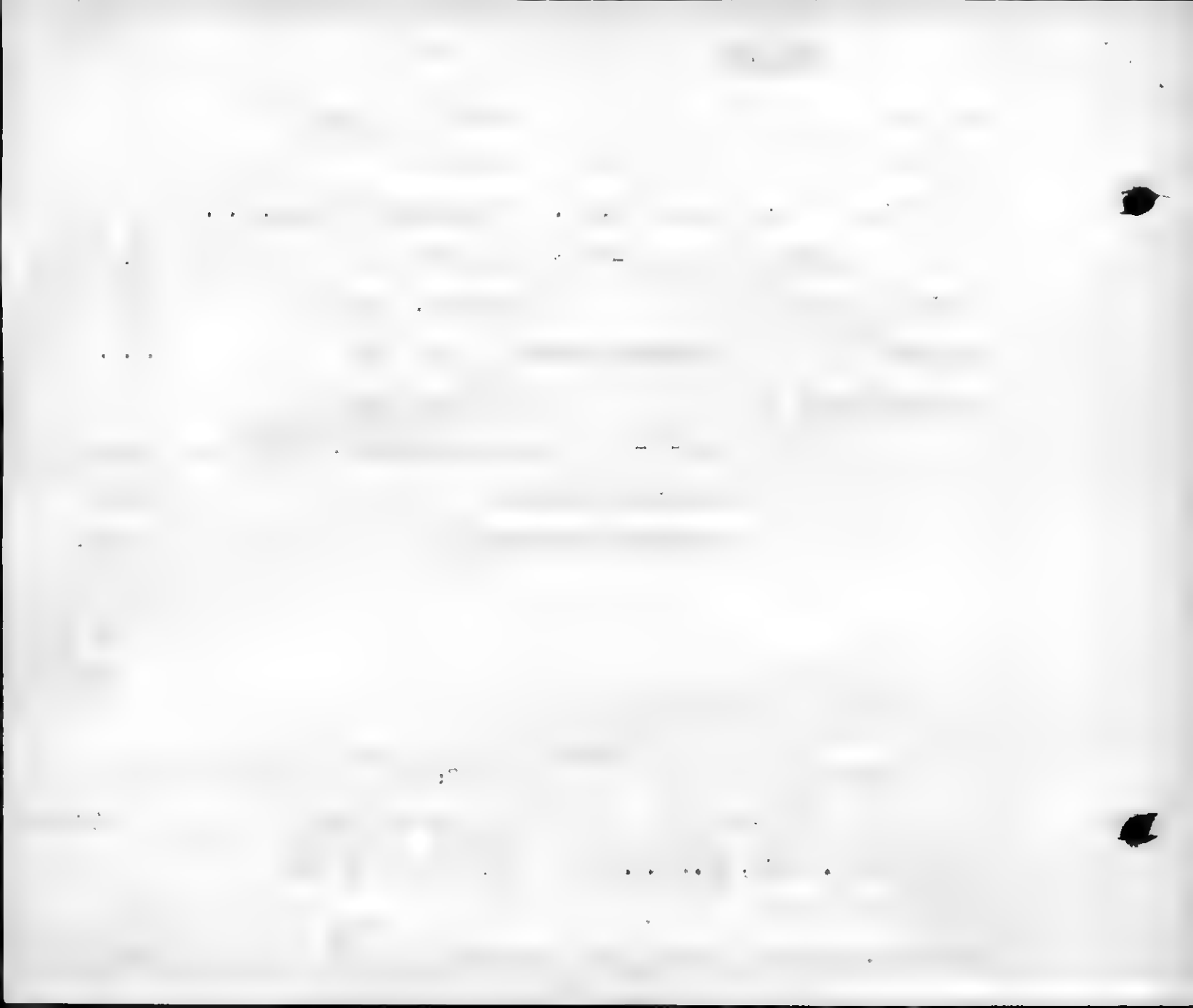
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN lb <b>249 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>4</b> d. STREET ADDRESS <b>2500 Wisconsin Avenue, N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Winifred Mary-Theresa Jacoutot</b>			4. DATE OF DEATH Month Day Year <b>October 11, 19 59</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 4, 1918</b>		9. AGE (In years lost birthday) yrs. <b>41</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Equipment Company</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>William Jacoutot</b>		
14. MOTHER'S MAIDEN NAME <b>Winifred Frewen</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>130-09-8993</b>			17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary congestion</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Carcinoma of the breast</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>7 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>	
21. I certify that I attended the deceased from <b>February 4, 1959</b> to <b>October 11, 1959</b> , that I last saw the deceased alive on <b>October 11, 1959</b> and that death occurred at <b>7:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>10/12/59</b> NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit 10/13/59</b>		22b. DATE THEREOF <b>10/13/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>New York, New York</b>		24a. REC'D BY REG STRAR DATE <b>OCT 14 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kincaid</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> <b>Bethesda, Maryland</b>					

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11617

## CERTIFICATE OF DEATH

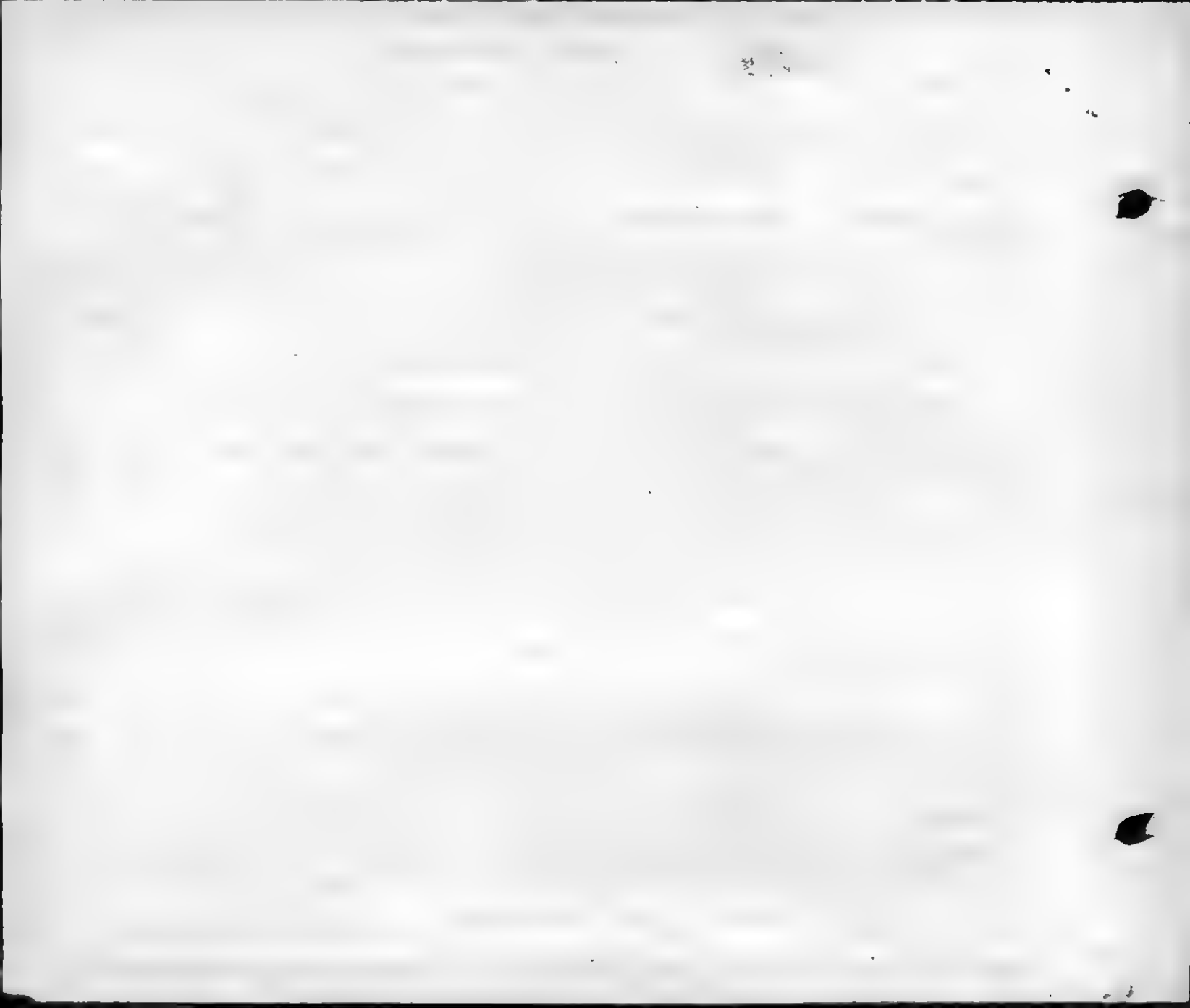
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Kensington</u>	
c. LENGTH OF STAY in lb <u>30 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10734 Conn. Ave</u>		d. STREET ADDRESS <u>10734 Conn. Ave.</u>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Norman C. Kefauver</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 1, 1877</u> 82 yrs.
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Printing</u>	
11. BIRTHPLACE (State or foreign country) <u>Montgomery Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Harmon C. Kefauver</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Routzahn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Brother</u> Address <u>10734 Conn. Ave</u>		<u>Mr. Vernon Kefauver Kensington, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>4:20.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>udden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 28, 1959</u> to <u>Oct. 20, 1959</u> , that I last saw the deceased alive on <u>Oct. 19, 1959</u> , and that death occurred at <u>11:15</u> M, from the causes and on the date stated above			
ACTUAL SIGNATURE <u>J. Marion Bankhead</u> M.D.		ADDRESS (Street, city or town, state) <u>9241 Col. Blvd</u> DATE SIGNED <u>10/20/59</u>	
PHYSICIAN'S NAME (Type) <u>J. Marion Bankhead Silver Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/23/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>DATE OCT 22 1959</u>	
		24b. REGISTRAR'S SIGNATURE <u>William P. K.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11577

11618

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN lb <u>4 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp.</u>				e. STREET ADDRESS <u>4710 Waverly Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>New</u> Last <u>Kelly</u>				4. DATE OF DEATH Month <u>October</u> Day <u>12</u> , Year <u>1959</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/3/1919</u>	
9. AGE (in years last birthday) <u>40</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>9</u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>New Brunswick, N.J.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>William A. New</u>				14. MOTHER'S MAIDEN NAME <u>Margaret McMannis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT <u>Hosp Record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Encephalomalacia</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cerebral contusions</u> (c) <u>Fractured Skull</u> DUE TO stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>4 days</u> <u>4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Thrombocytopenia</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Reported to have fallen down basement steps at home</u>			
20c. TIME OF INJURY Month, Day, Year <u>10/7/59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) (County) (State) <u>Garret Pk. Montg. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-14-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate in a sealed envelope, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 to the medical examiner. The Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





11513

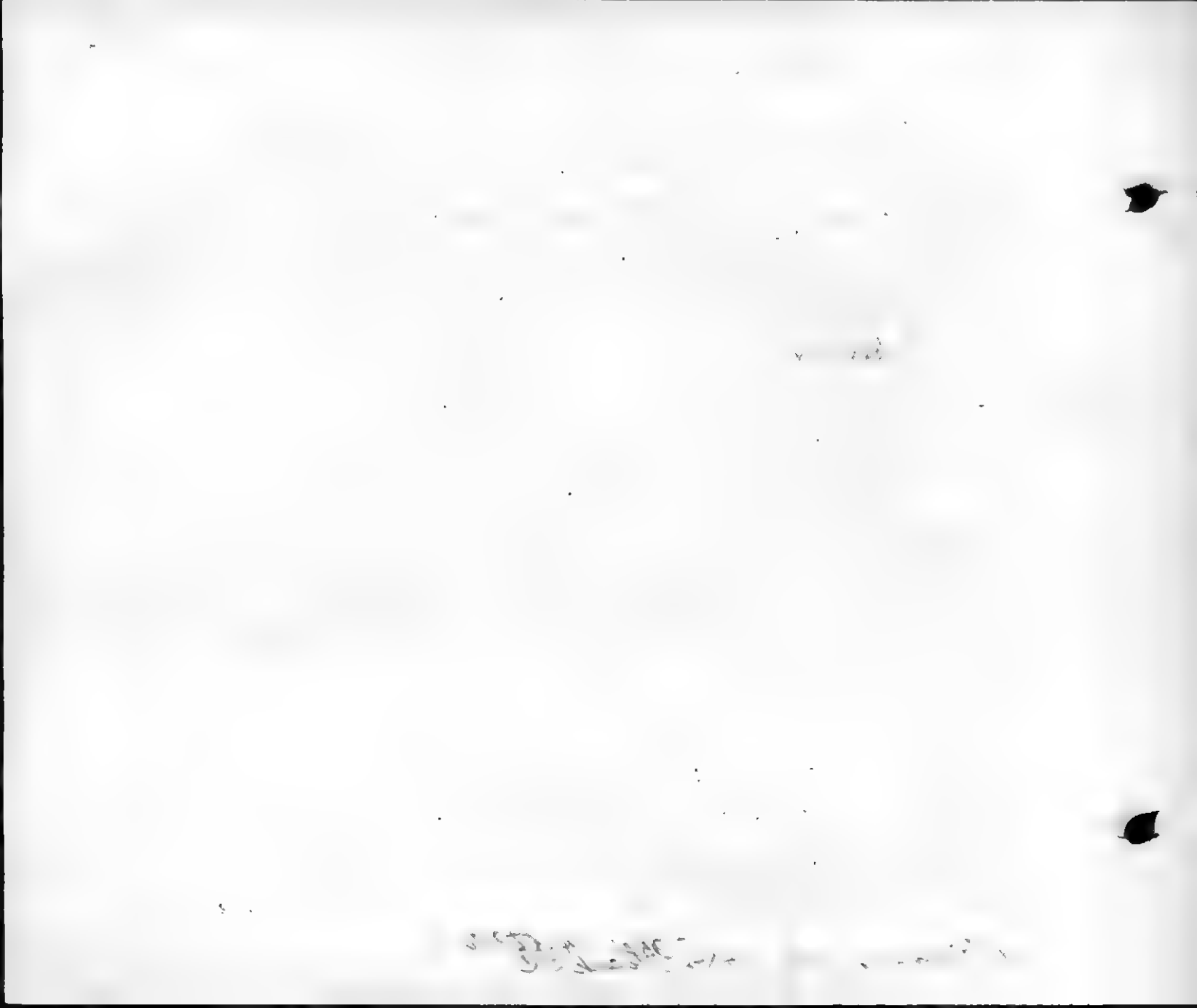
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>—</u> b. COUNTY <u>—</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakewood Park</u>				c. LENGTH OF STAY IN 1b <u>3 mos-7 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium &amp; Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Jacob</u> Middle <u>William</u> Last <u>Kriegel</u>				4. DATE OF DEATH Month <u>10</u> Day <u>21</u> Year <u>1959</u>			
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-16-75</u>	9. AGE (In years last birthday) <u>83</u> yn	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Artist-Lithographer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>America</u>							
13. FATHER'S NAME <u>Samuel Kriegel</u>				14. MOTHER'S MAIDEN NAME <u>Rachel Ginsburg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Hospital Records</u>				Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> DUE TO							INTERVAL BETWEEN ONSET AND DEATH <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>—</u>	(County) <u>—</u>	(State) <u>—</u>		
21. I certify that I attended the deceased from <u>Oct. 20, 1959</u> , to <u>Oct 21, 1959</u> , that I last saw the deceased alive on <u>Oct. 20, 1959</u> , and that death occurred at <u>3:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Abraham W. Danish</u>		M.D. <u>—</u>		ADDRESS (Street, city or town, state) <u>927 PERSHING DR</u>		DATE SIGNED <u>10-21-59</u>	
PHYSICIAN'S NAME (Type) <u>ABRAHAM W. DANISH</u>		<u>SILVER SPRING, MD</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>Oct. 22, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Lebanon Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hyattsville, MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Danzansky</u>		ADDRESS <u>3521-18 ST NW</u>		24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kane</u>	
				DATE <u>OCT 23 '59</u>			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 of the death certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11537

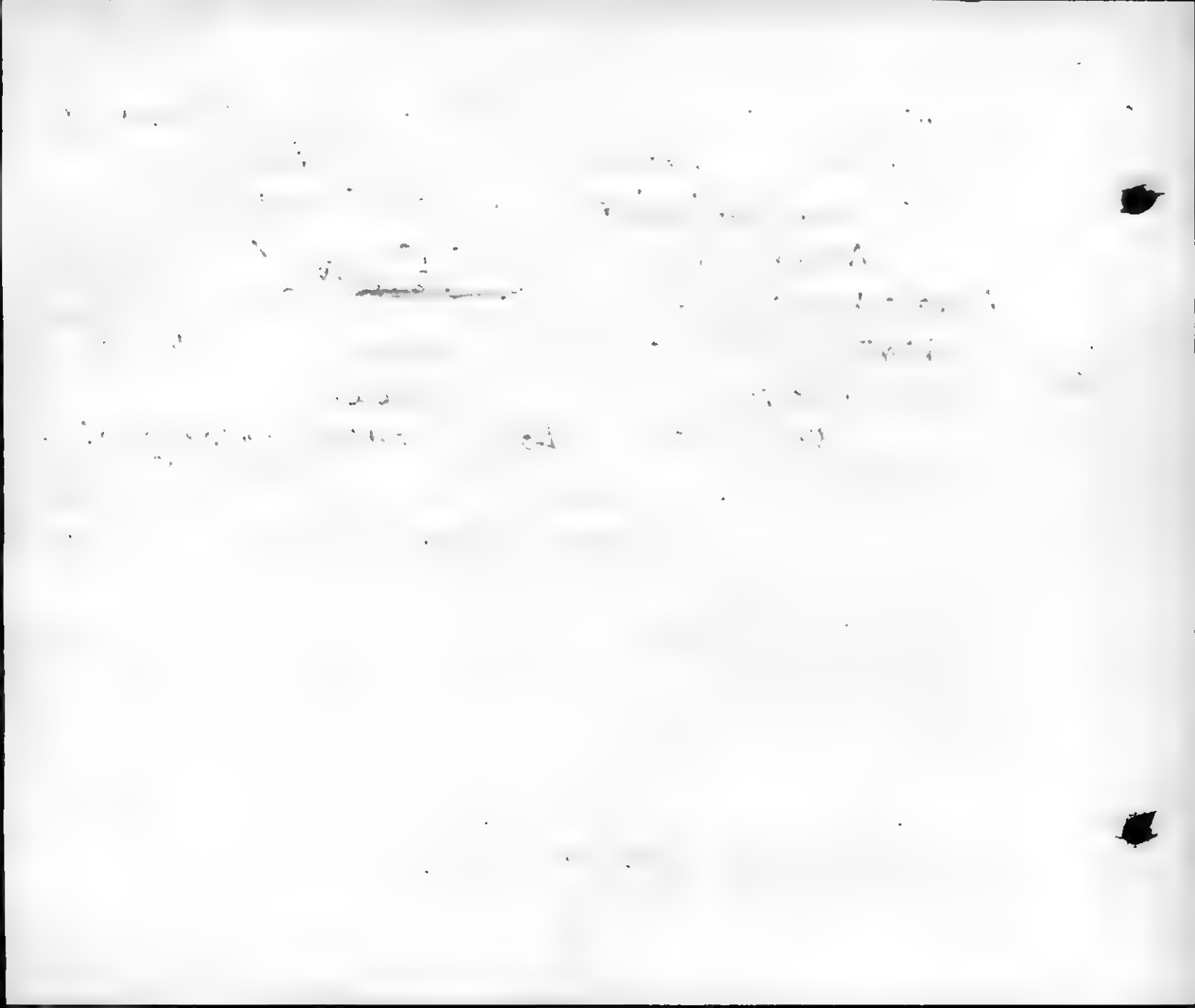
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <b>Md.</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. LENGTH OF STAY IN lb <b>27mo 8 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Waverley Sanitarium</b>		e. STREET ADDRESS <b>4-West Irving St.</b>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>H</b> Last <b>Ladd</b>		4. DATE OF DEATH Month <b>10</b> Day <b>15</b> Year <b>1959</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-14-1865</b> AGE (In years last birthday) <b>94</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	11. BIRTHPLACE (State or foreign country) <b>Mass.</b>
13. FATHER'S NAME <b>H. Hammond</b>		14. MOTHER'S MAIDEN NAME <b>Kimball</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>—</b>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>Myocardial decompensation, acute 7 days</b> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. <b>Arteriosclerosis, general, severe 5 yrs +</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitis</b>		18. INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>—</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>—</b> p. m. <b>—</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1955</b> to <b>Oct 15, 1959</b> , that I last saw the deceased alive on <b>Oct 7, 1959</b> , and that death occurred at <b>545a</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stewart Clapp</b> M.D.		ADDRESS (Street, city or town, state) <b>3921 Ingomar St. Wash 15 DC</b>	
PHYSICIAN'S NAME (Type) <b>Stewart Clapp</b>		DATE SIGNED <b>10/15/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	22b. DATE THEREOF <b>10/17/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>	22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>DATE OCT 19 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Clinton S. Thomas</b>

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11514

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lathrop Park</u>		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Pr. George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Can Haven Rest Home</u>		d. STREET ADDRESS <u>3325 Chaucey Pl.</u>	
3. NAME OF DECEASED (Type or print) <u>Mary Elizabeth White Lister</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>30</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-31-1893</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>Vermont</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>CHARLES MEARS</u>		14. MOTHER'S MAIDEN NAME <u>MINNIE MOREY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Adorothy Parchin</u>		Address <u>Same as 2A</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>adenocarcinoma posterior mediastinum</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>chronic advanced generalized arthritis</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>chronic advanced generalized arthritis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 15, 1959</u> to <u>Oct 30, 1959</u> , that I last saw the deceased alive on <u>10/29, 1959</u> and that death occurred at <u>12:40 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Daniel B. Washington</u> M.D.		ADDRESS (Street, city or town, state) <u>6234 90 Ave NW Wash DC</u>	
PHYSICIAN'S NAME (Type) <u>Daniel B. Washington M.D.</u>		DATE SIGNED <u>10/30/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-2-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FT LINCOLN CEM</u>		22d. LOCATION (City, town, or county) (State) <u>BLADENSBURG MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers C</u>		ADDRESS <u>1400 Chapin St NW Wash D.C.</u>	
24a. REC'D BY REGISTRAR <u>NOV 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11581

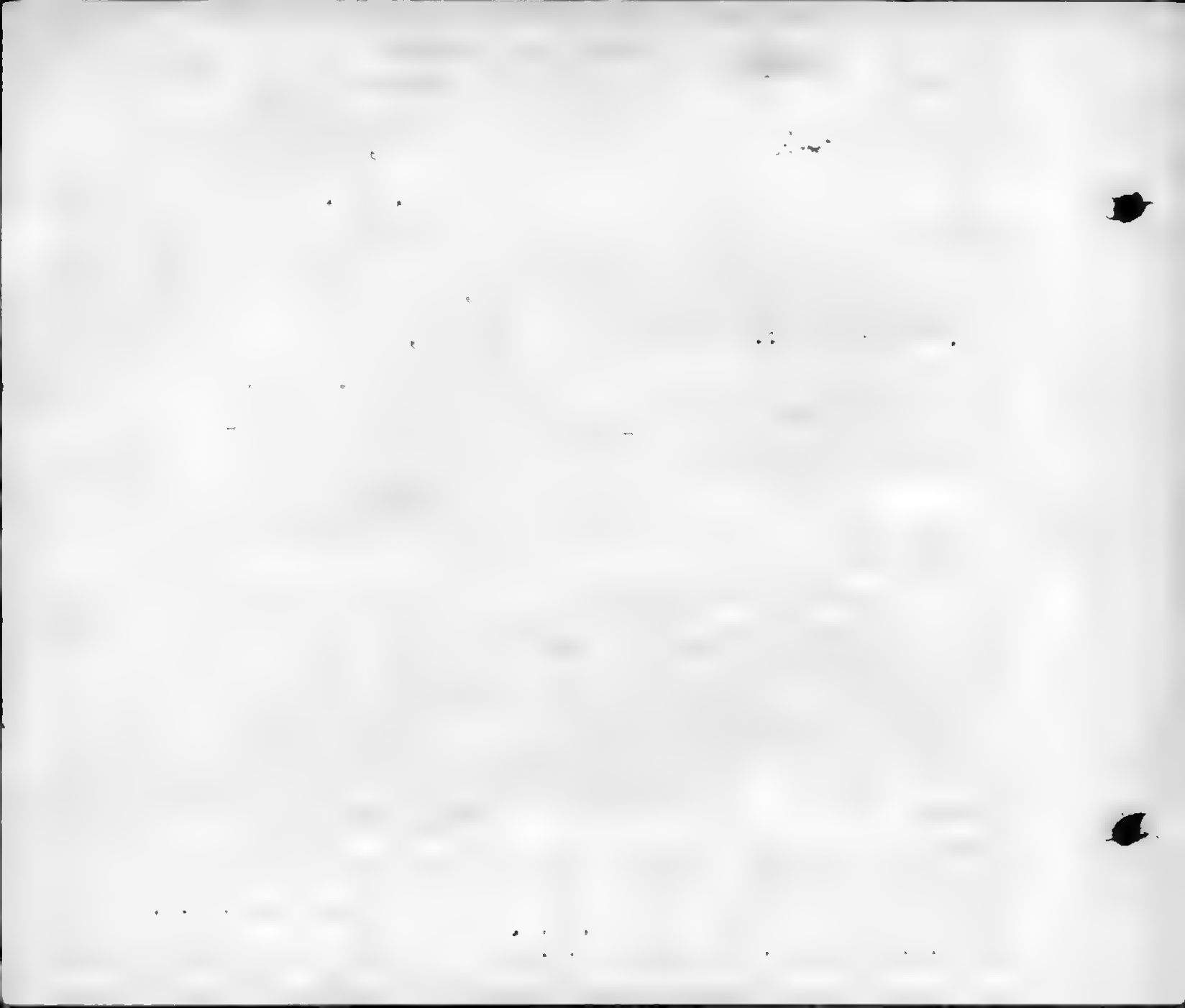
11619

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington, DC</u> b. COUNTY <u>41X</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, DC</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>4600 Conn. Ave. NW</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>J</u> Middle <u>Stanley</u> Last <u>Long</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>1</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 20, 1888</u>
9. AGE (In years last birthday) yrs. <u>71</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Insurance Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Long &amp; Curry</u>	
11. BIRTHPLACE (State or foreign country) <u>Altoona, Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Long</u>		14. MOTHER'S MAIDEN NAME <u>Belle M. Bowles</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>577-03-7411</u>	
17. INFORMANT <u>Edna Galleher Long</u>		Address <u>4600-Conn Ave NW</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of prostate with</u> <u>wide-spread metastases</u> DUE TO (b) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8-16-</u> 19 <u>59</u> , to <u>Oct 1</u> 19 <u>59</u> , that I last saw the deceased alive on <u>Sept 30</u> 19 <u>59</u> , and that death occurred at <u>10:15</u> AM, from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Stephen W. Deiter</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>3921 Ingomar St NW Wash, DC</u>	
PHYSICIAN'S NAME (Type) <u>STEPHEN W. DEITER MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>10/3/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 5 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>William A. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





11620

## CERTIFICATE OF DEATH

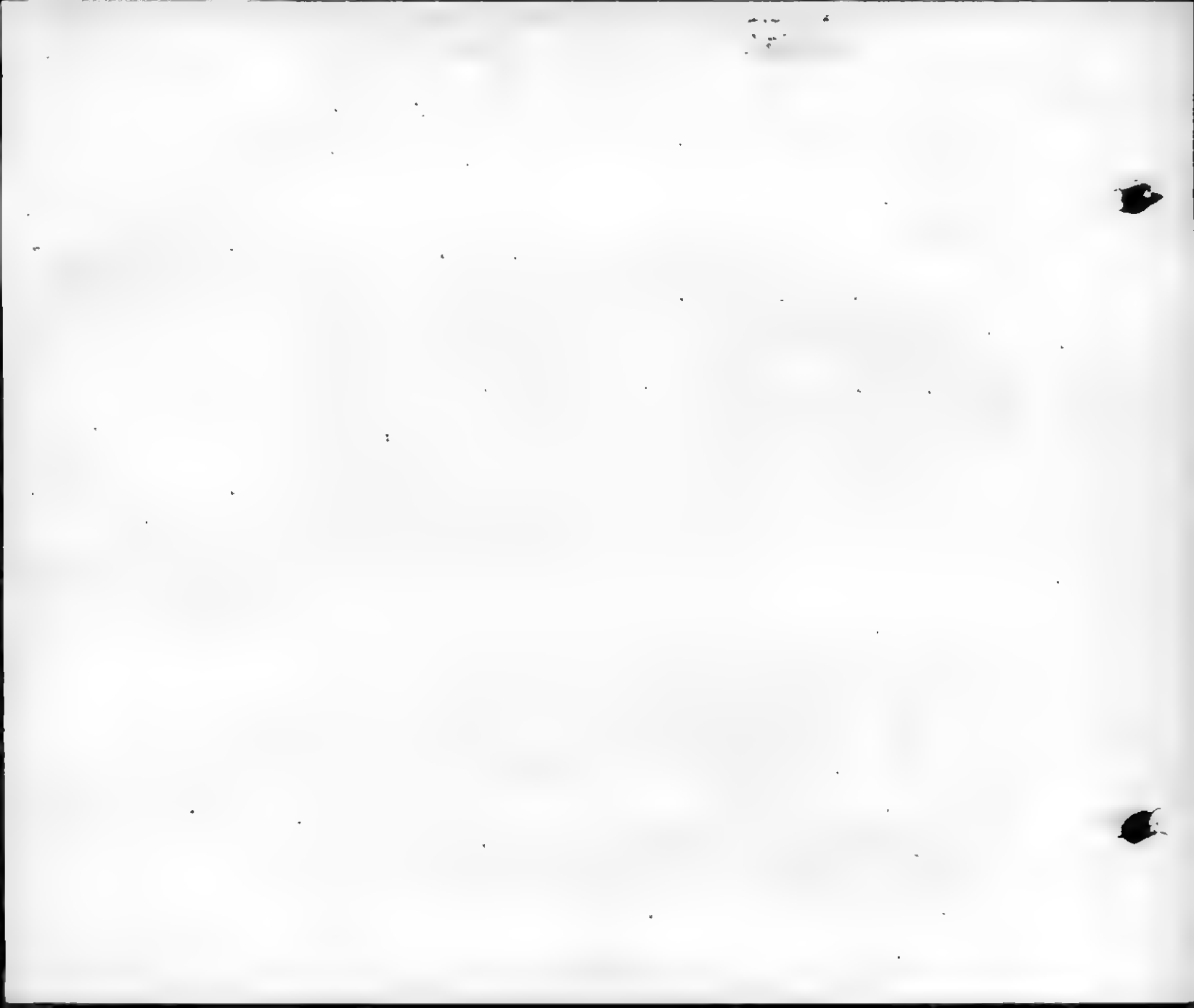
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ST. MARY'S</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN lb <u>1 WEEK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>BENEDICT BASIL LOVE</u>		4. DATE OF DEATH Month Day Year <u>OCTOBER 21 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 9, 1871</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNDERTAKER-MERCHANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MA</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>PHILIP GREENWELL LOVE</u>		14. MOTHER'S MAIDEN NAME <u>JOSEPHINE BOND</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>NO.</u>	
17. INFORMANT <u>MRS. ANNA MICKOM</u>		Address <u>9906 HURST ST. BETHESDA 14, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY ARTERIOSCLEROSIS (ANGINA PECTORIS)</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS; (CARCINOMA (SKIN - FACE))</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 HOURS</u> <u>SEVERAL YEARS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>GENERALIZED ARTERIOSCLEROSIS; (CARCINOMA (SKIN - FACE))</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>OCTOBER 14, 1959</u> , to <u>OCTOBER 21, 1959</u> that I last saw the deceased alive on <u>OCTOBER 21, 1959</u> , and that death occurred at <u>12:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph D. Connor</u>		ADDRESS (Street, city or town, state) <u>9420 OLD GEORGETOWN RD. 21 OCT. 59</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH D. CONNOR, M.D.</u>		DATE <u>BETHESDA 14, MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/24/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's</u>	22d. LOCATION (City, town, or county) (State) <u>Morganza, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattingley</u>		ADDRESS <u>Leonardtwn, Maryland</u>	
24a. REC'D BY REGISTRAR DATE <u>OCT 26 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

11621

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11583

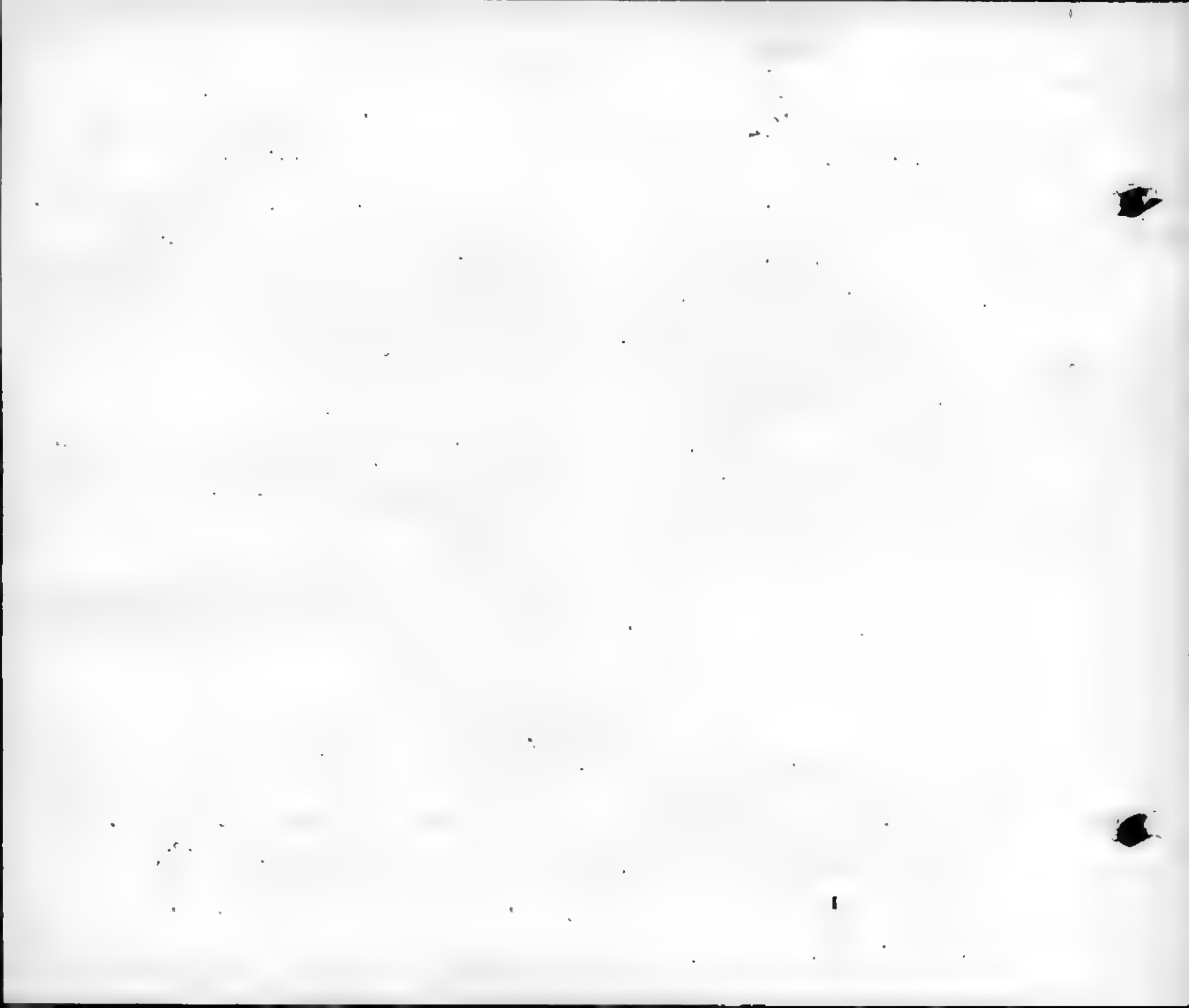
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Same Spring</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		d. STREET ADDRESS <i>526 Geneva Ave -</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>MARY M LUCKETT</i>		4. DATE OF DEATH Month Day Year <i>10 - 30 1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Caucasian</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/20/1922</i>
9. AGE (In years last birthday) <i>66</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Hostess</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	
11. BIRTHPLACE (State or foreign country) <i>Bethesda, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Tom Brown</i>		14. MOTHER'S MAIDEN NAME <i>Leona ?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>Yes -</i>	
17. INFORMANT <i>Ralph Lockett</i> Address <i>Son 1525 1/2 Ave. N.W.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Infarct, recent, right parietal lobe, Brain</i> DUE TO (b) <i>15 days</i> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) <i>15 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Brucellosis, bilateral</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>10/19</i> , 19 <i>59</i> , to <i>10/30</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>10/30</i> , 19 <i>59</i> , and that death occurred at <i>1</i> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John B. Underman</i> M.D.		ADDRESS (Street, city or town, state) <i>5805 Conn. Ave</i> DATE SIGNED <i>10/31/59</i>	
PHYSICIAN'S NAME (Type) <i>John B. Underman</i>		<i>Cherry Chase 15, Md.</i>	
22a. BURIAL, CREMATION, or other disposition (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11/3/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Ash Memorial</i>	22d. LOCATION (City, town, or county) (State) <i>Sandy Spring, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert C. Underman</i> ADDRESS <i>Rockville, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 5 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur P. Thomas</i>

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cardbox papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



1

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

11584

11515

**CERTIFICATE OF DEATH**

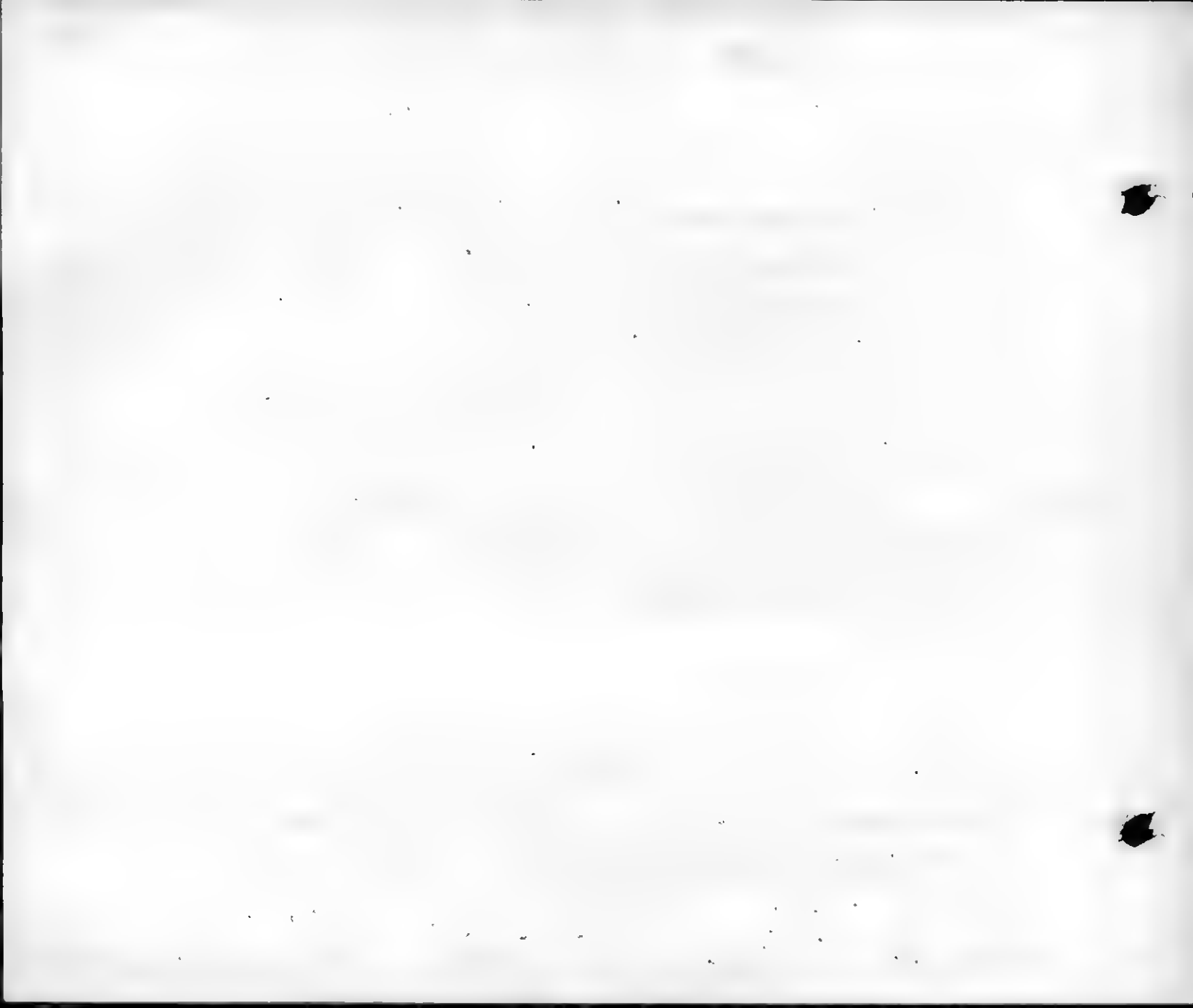
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hosp.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
f. STREET ADDRESS <u>1104 Kathryn Rd.</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Bennett</u> Last <u>Lyon</u>		4. DATE OF DEATH Month <u>10</u> Day <u>17</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-20-80</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired D.C. Fire Department</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bn. Chief</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nash Lyon</u>		14. MOTHER'S M maiden NAME <u>FRANCES TUCKER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>wife &amp; old Hospital Records</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 173X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Prostate with Metastatic Carcinoma to Lung</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>April 1959</u> <u>1955</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 16, 1959</u> , to <u>October 17, 1959</u> , that I last saw the deceased alive on <u>October 17, 1959</u> , and that death occurred at <u>8:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stuart L. Nelson</u>		ADDRESS (Street, city or town, state) <u>Md. 7600 Carroll Avenue Takoma Park, Md.</u> DATE SIGNED <u>10/17/59</u>	
PHYSICIAN'S NAME (Type) <u>STUART L. NELSON M.D.</u>		M.D. <u>  </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>	22b. DATE THEREOF <u>10/20/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Mausoleum</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. [unclear]</u>		ADDRESS <u>8434 [unclear]</u> REC'D BY REGISTRAR <u>  </u> DATE <u>OCT 20 '59</u>	
24. REGISTRAR'S SIGNATURE <u>  </u>		25. REGISTRAR'S SIGNATURE <u>  </u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VS A15 (4)  
15M 9/58



11622

## CERTIFICATE OF DEATH

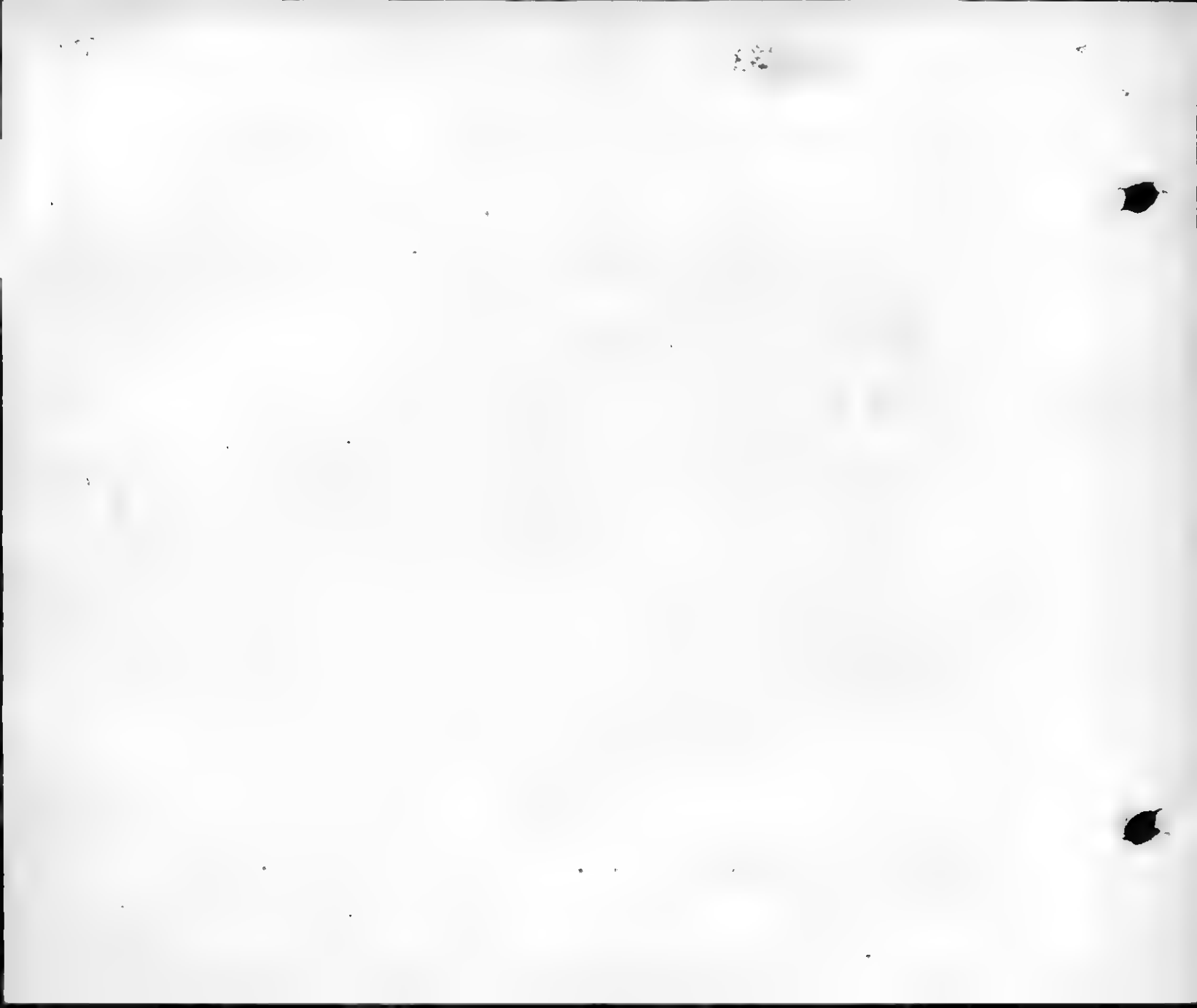
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		c. LENGTH OF STAY IN 1b <b>4 DAYS</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DERWOOD</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY COUNTY GENERAL HOSPITAL</b>				e. STREET ADDRESS <b>Rt. #1 Box 105</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ANNA SOUTHERLAND MACLEAN</b>		4. DATE OF DEATH Month Day Year <b>OCTOBER 9 19 59</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/10/72</b>	9. AGE (In years lost birthday) <b>87 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>MICHIGAN</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>WILLIAM LOWE</b>		
14. MOTHER'S MAIDEN NAME <b>MARY MASON Dunn</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT Address <b>HOSPITAL RECORDS OLNEY, MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebro-Vascular Hemorrhage</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Non-united hip fracture</b>					INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1955 to Oct 9, 1959</b> , that I last saw the deceased alive on <b>Oct 8, 1959</b> , and that death occurred at <b>10:22A</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>10/9/59</b>					
ACTUAL SIGNATURE <b>Richard A. Yates</b>		M.D. <b>10/9/59</b>			
PHYSICIAN'S NAME (Type) <b>RICHARD A. YATES, M. D.</b>		<b>OLNEY, MARYLAND</b>			
22a. BURIAL, CREMAT., OR REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/12/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 13 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur E. Frank</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

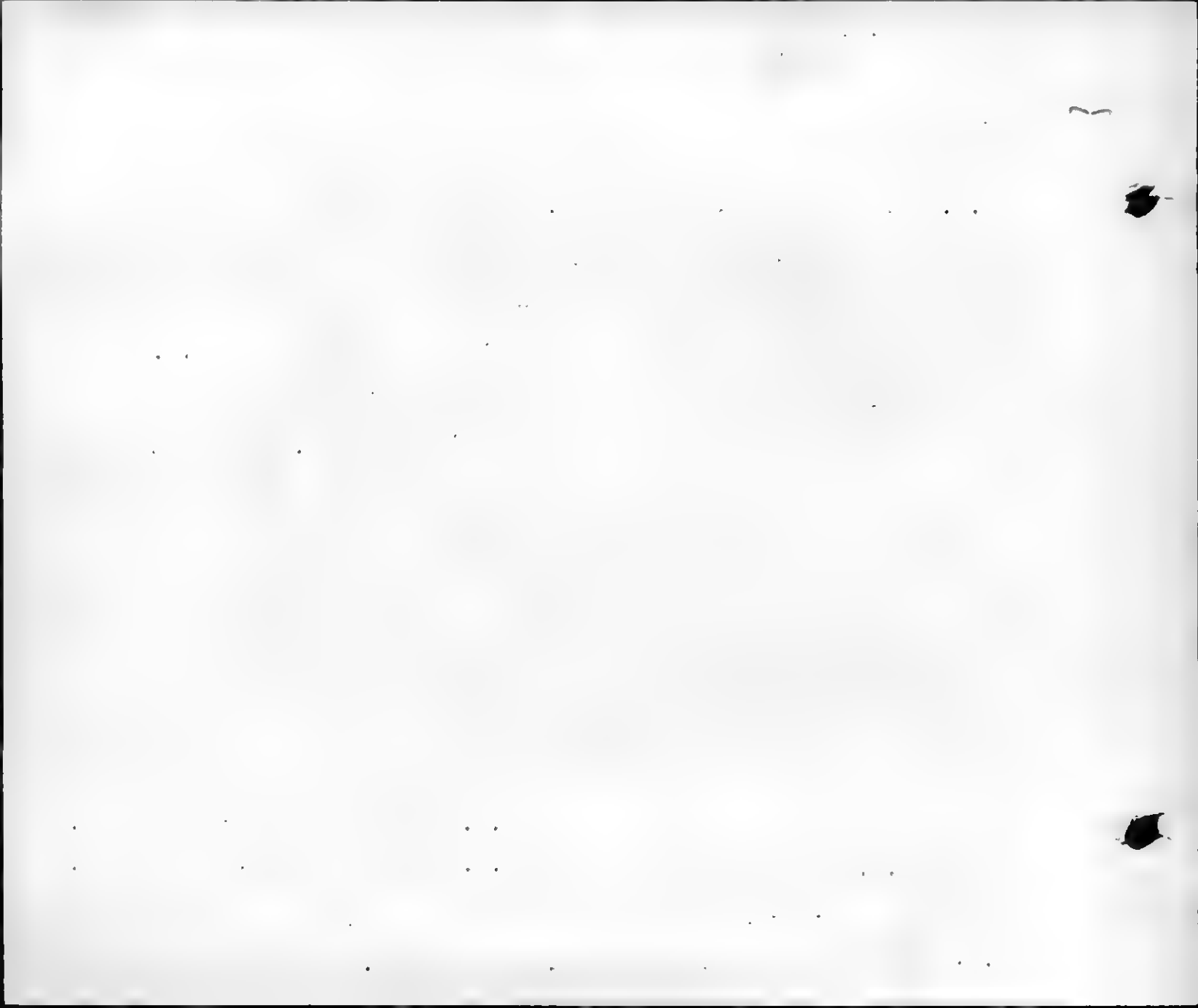




11623 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 CERTIFICATE OF DEATH

11586  
 Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN lb <b>7 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY <b>Parkersburg</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>1608 Race Street</b> d. STREET ADDRESS <b>1608 Race Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Claire Keturah MANDIGO</b>				4. DATE OF DEATH Month Day Year <b>October 19 1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-3-92</b>	
9. AGE (In years last birthday) <b>67</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	
13. FATHER'S NAME <b>James BURTON</b>				14. MOTHER'S MAIDEN NAME <b>Fannie LOCKHART</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO <b>(Husband) Brayton W. MANDIGO Same as #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Asphyxiation due to Food</b> <b>350X</b> DUE TO (b) <b>PARALYSIS agitans</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 20f. (City or town) (County) (State)							INTERVAL BETWEEN ONSET AND DEATH <b>2 min.</b>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21. I certify that I attended the deceased from <b>12 October 1959</b> to <b>19 October 1959</b> , that I last saw the deceased alive on <b>19 October 1959</b> , and that death occurred at <b>8:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda Md.</b>							
ACTUAL SIGNATURE <b>R. G. Muth</b> M.D. <b>U.S. Naval Hospital, Bethesda Md.</b>							
PHYSICIAN'S NAME (Type) <b>R. G. MUTH LT MC USN</b> <b>U.S. Naval Hospital, Bethesda Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-21-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumphrey</b>				24a. REC'D BY REGISTRAR <b>7557 Wisconsin Ave. Bethesda Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Oct 23 '59</b>	



11624

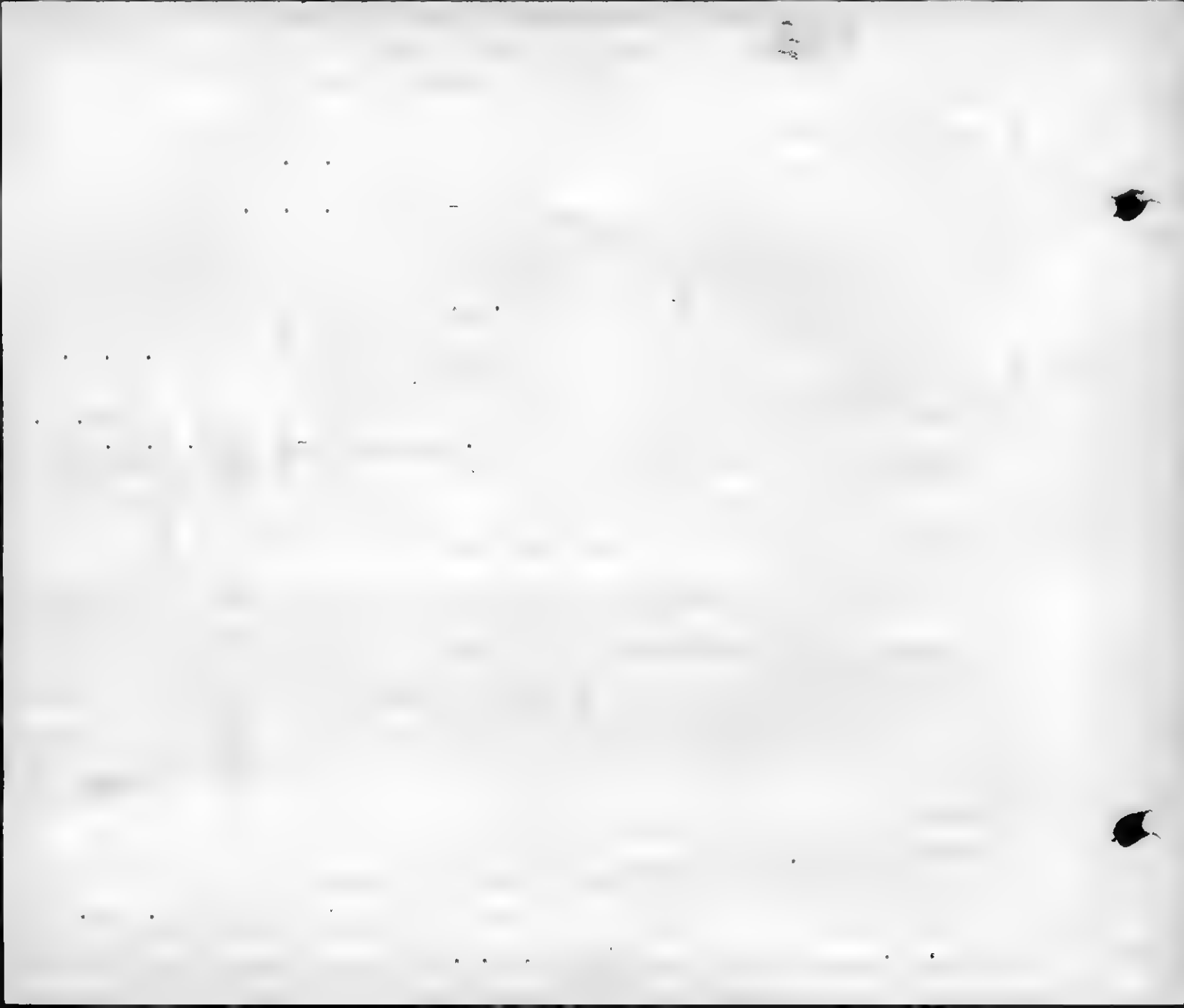
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Carroll Hall Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D. C.</b> d. STREET ADDRESS <b>5614 - 32nd St. N. W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HARRIETT M. MANN</b>		4. DATE OF DEATH Month <b>10</b> Day <b>29</b> Year <b>1959</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 23, 1876</b>
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>3</b> Days <b>29</b> Hours <b>19</b> Min <b>59</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Jesse McLendon</b>		14. MOTHER'S MAIDEN NAME <b>Marie Mitchener</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Frank J. Mann</b>		Address <b>Wash. D.C. -5534 -30th St. N. W.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>296X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <b>Thrombocytopenic Purpura</b> (c) <b>Idiopathic Aplastic Anemia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>1 year</b> <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>APRIL 15, 1959</b> to <b>10-29, 1959</b> , that I last saw the deceased alive on <b>10-29, 1959</b> , and that death occurred at <b>11:10</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Peyton R. Evans</b>		ADDRESS (Street, city or town, state) <b>Washington Clinic, Wash D.C.</b>	
PHYSICIAN'S NAME (Type) <b>Peyton R. Evans</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/31/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Prince Georges Co. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Company</b>		ADDRESS <b>Washington, D.C.</b>	
24a. REC'D BY REGISTRAR <b>OCT 30 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

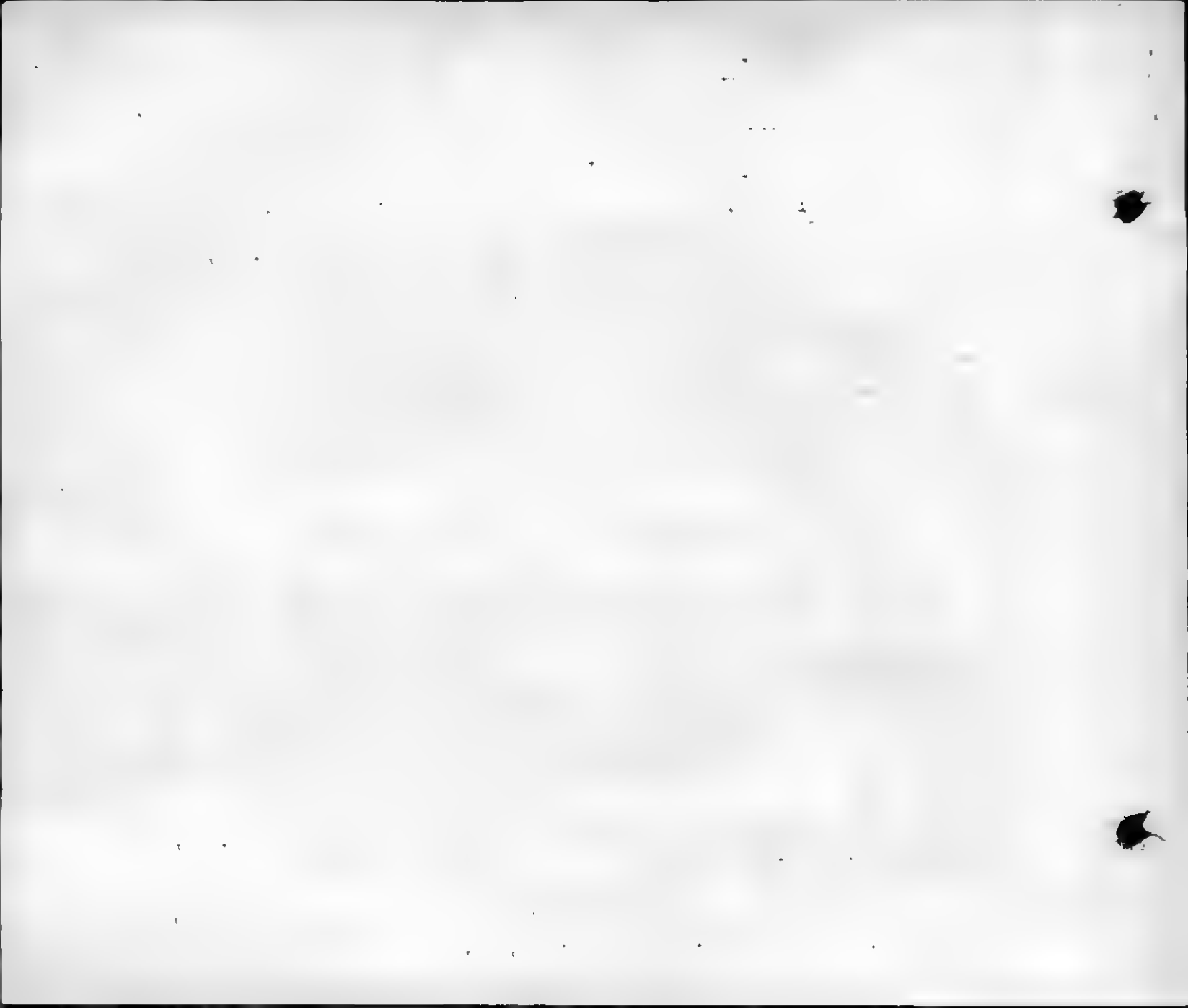
## 11625 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11588

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN 1b <b>5 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2005 Shorefield Rd.</b>			<b>2. USUAL RESIDENCE</b> (Where deceased lived If institution; Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Montg.</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d. STREET ADDRESS <b>2005 Shorefield Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <b>Sylvia</b> <span style="float: right;">First</span> <b>MATRIKIAN</b> <span style="float: right;">Middle</span> <b>Matoian</b> <span style="float: right;">Last</span>			<b>4. DATE OF DEATH</b> <b>Oct. 25, 1959</b> <span style="float: right;">Month</span> <span style="float: right;">Day</span> <span style="float: right;">Year</span> <b>19</b>		
<b>5. SEX</b> <b>female</b>		<b>6. COLOR OR RACE</b> <b>white</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
<b>8. DATE OF BIRTH</b> <b>8/15/1894</b>			<b>9. AGE</b> (in years last birthday) <b>65</b> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <b>0</b> Days <b>0</b>
<b>11. IF UNDER 24 HRS</b> Hours <b>0</b> Min. <b>0</b>			<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Home maker</b>		
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>own home</b>			<b>11. BIRTHPLACE</b> (State or foreign country) <b>Armenia</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>
<b>13. FATHER'S NAME</b> <b>Unknown Astor Balian</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown Mary Neshanian</b>		
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>Troy Peters (son in law)</b> <span style="float: right;">Address</span> <b>Item 2</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO <b>Hypertention</b> Conditions, if any, which gave rise to immediate cause (b) <b>(a), stating the underlying cause last.</b> DUE TO (c)					
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>					
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/></b>			
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)				<b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b>	
<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/></b>					
<b>ACTUAL SIGNATURE</b> <i>Frank J. Broschart</i> <span style="float: right;">M.D.</span>			<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <span style="float: right;">DATE SIGNED</span> <b>Oct. 25, 1959</b>		
<b>EXAMINER'S NAME (Type)</b> <b>Frank J. Broschart</b>			<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>		
<b>22a. BURIAL, CREMATION REMOVAL (Specify)</b> <b>BURIAL</b>		<b>22b. DATE THEREOF</b> <b>10/28/59</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>PARKLAWN CEMETERY</b>	
<b>22d. LOCATION (City, town, or county)</b> <b>MONTGOMERY COUNTY, MARYLAND</b>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>WARNER E. PUMPHREY, INC.</b> <span style="float: right;">ADDRESS</span> <b>SILVER SPRING, MD.</b>			
<b>24a. RECORD BY REGISTRAR</b> <b>OCT 28 1959</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Raymond G. Ziska</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11626

## CERTIFICATE OF DEATH

11589

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHEATON WOODS</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <u>4600 - GLASGOW DR.</u>	
3. NAME OF DECEASED (Type or print) First <u>ANTONIO</u> Middle <u>MAZZARA</u> Last <u>MAZZARA</u>		4. DATE OF DEATH Month <u>10</u> - Day <u>18</u> - Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-13-1895</u>
9. AGE (In years, last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>10</u> Days <u>18</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>ITALY</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>SALVATORE MAZZARA</u>		14. MOTHER'S MAIDEN NAME <u>CALEDONIA ACESTE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>053-09-3133</u>	
17. INFORMANT <u>CLARA GIACALONE</u>		Address <u>4600 - GLASGOW DR.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic capillary</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Tuberculosis of lung</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Seven yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]	
20c. TIME OF INJURY Month <u>10</u> Day <u>19</u> Year <u>1959</u> Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>October 10, 1959</u> to <u>October 10, 1959</u> , that I last saw the deceased alive on <u>October 10, 1959</u> , and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Dr. John H. Trench</u>		ADDRESS (Street, city or town, state) <u>William T. Marcus MD</u>	
PHYSICIAN'S NAME (Type) <u>John H. Trench MD</u>		DATE SIGNED <u>William T. Marcus MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-21-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Hannon</u>		ADDRESS <u>3831 - GR. Ave</u>	
24a. REC'D BY REGISTRAR <u>22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>C. S. G. G. G.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in, should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

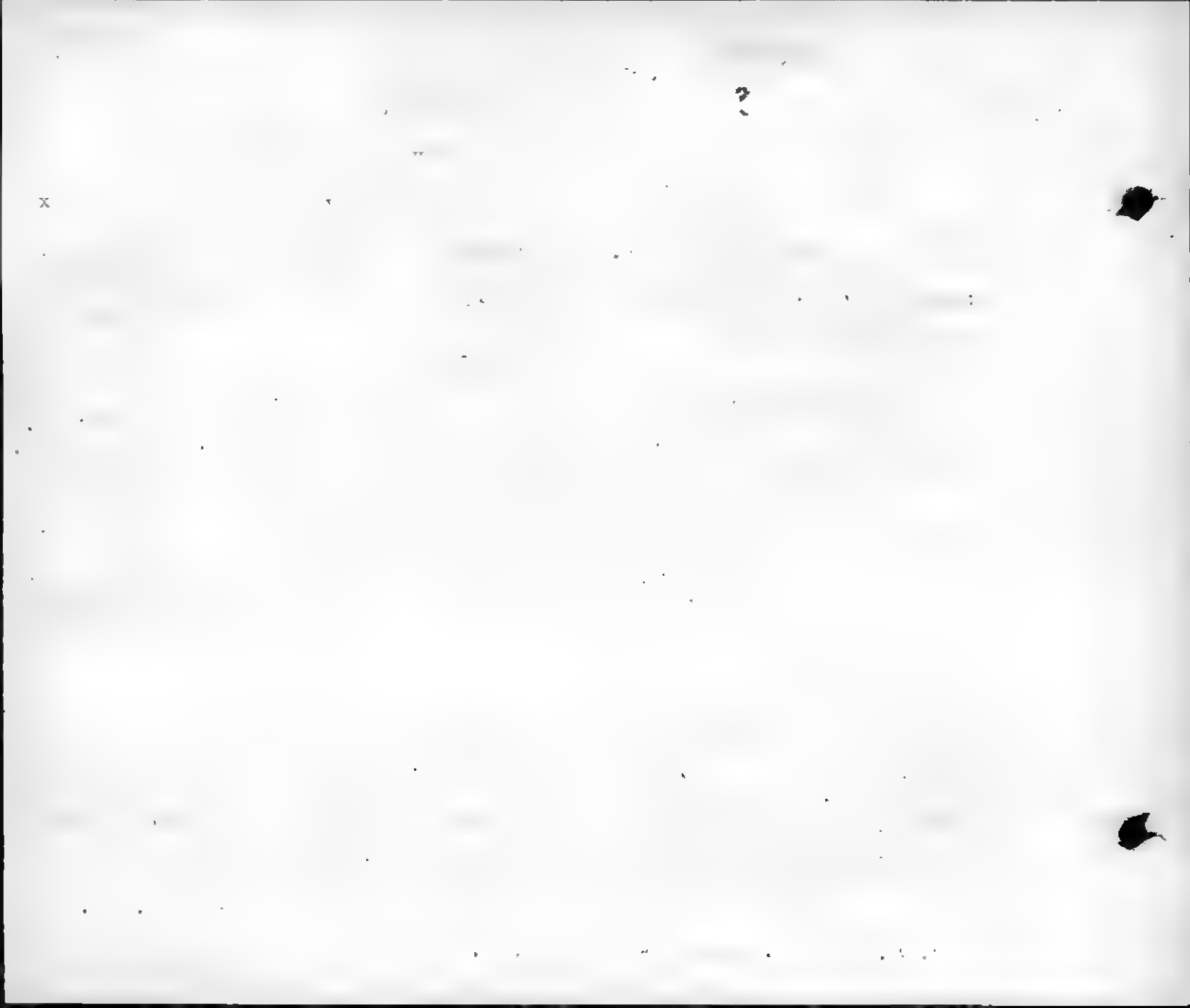
11627

## CERTIFICATE OF DEATH

Reg. Dist. No.

11591

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>1</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> d. STREET ADDRESS <b>7407 Meadow Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Marie</b> Middle <b>B.</b> Last <b>McCathran</b>		4. DATE OF DEATH Month <b>10</b> Day <b>22</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/18/78</b>
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR: Months <b>10</b> Days <b>22</b>	IF UNDER 24 HRS: Hours <b>19</b> Min. <b>59</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>(unknown) Sweeney</b>		14. MOTHER'S MAIDEN NAME <b>Julia Qui 11</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Daughter (Mrs. G. Lauding)</b>		Address <b>7407 Meadow La. Chevy Chase, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia, terminal</b> 446x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Nephroticosis, severe</b> DUE TO (c) <b>Hypertension, severe</b>		INTERVAL BETWEEN ONSET AND DEATH <b>One month</b> <b>2 yrs +</b> <b>5 yrs +</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1954</b> to <b>Oct 22, 1959</b> , that I lost saw the deceased alive on <b>Oct 21, 1959</b> , and that death occurred at <b>10:05</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stewart Clapp</b>		ADDRESS (Street, city or town, state) <b>3921 Ingomar St. N.W. Wash D.C.</b>	
PHYSICIAN'S NAME (Type) <b>Stewart Clapp</b>		DATE SIGNED <b>10/22/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/24/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Prince Georges Co. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Company</b>		24a. REC'D BY REGISTRAR <b>Washington, D.C.</b>	
24b. REGISTRAR'S SIGNATURE <b>DATE OCT 23 '59</b>		24c. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	



1  
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

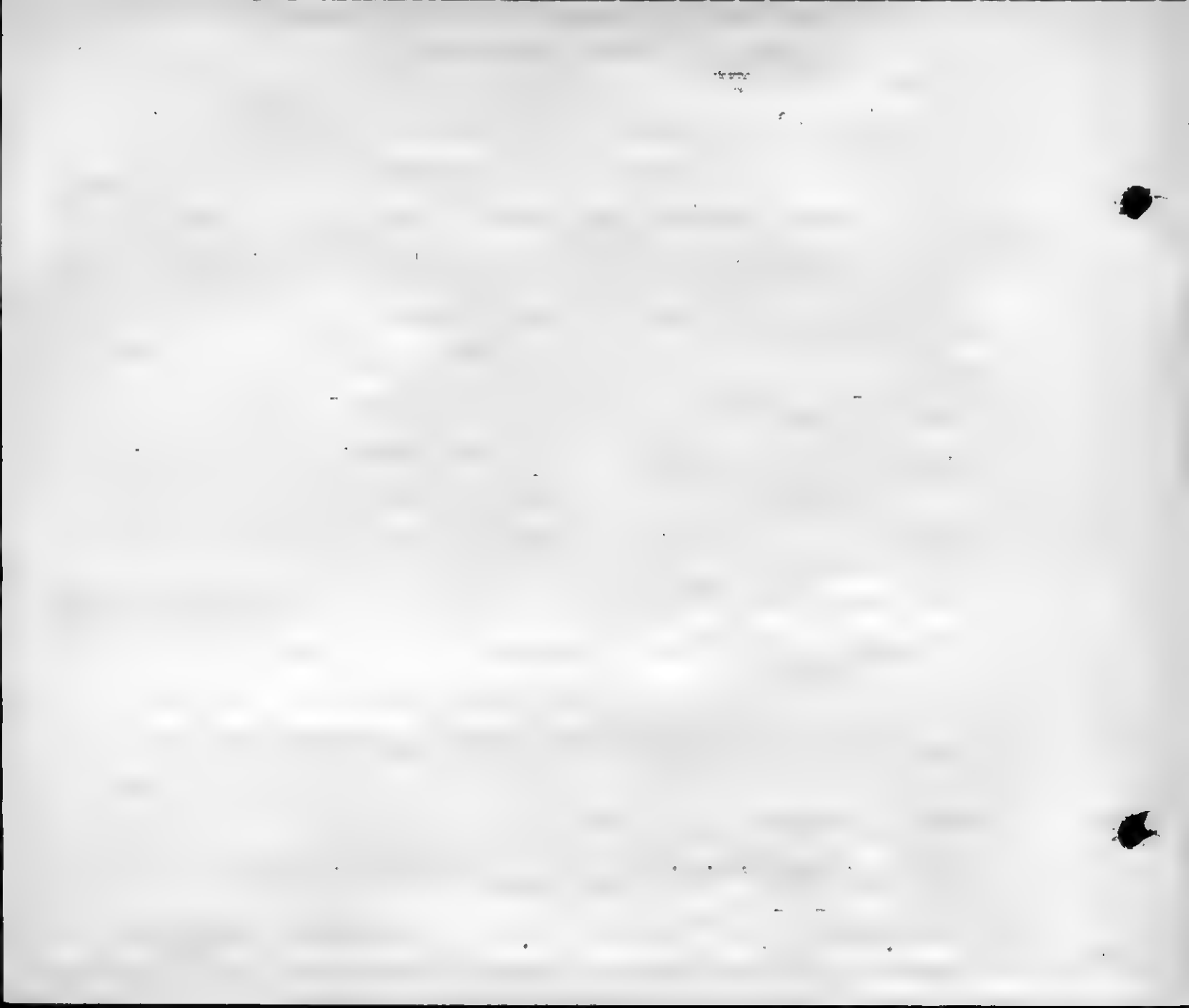
11628

## CERTIFICATE OF DEATH

Reg. Dist. No.

11592

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		c. LENGTH OF STAY IN 1b <b>8 DAYS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>MONTGOMERY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GAITHERSBURG</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY COUNTY GENERAL HOSPITAL</b>						/d. STREET ADDRESS <b>RT. #3</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ALPHA</b>		Middle <b>JANE</b>		Last <b>MC CONNELL</b>		4. DATE OF DEATH Month <b>OCTOBER</b>		Day <b>8</b>		Year <b>19 59</b>	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/21/02</b>		9. AGE (In years last birthday) yrs. <b>57</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home Work</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Alfred McConnell</b>						14. MOTHER'S MAIDEN NAME <b>Ida Gill -</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>		17. INFORMANT <b>HOSPITAL RECORDS,</b>				Address <b>OLNEY, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Vascular Accident</b> 10 days (c) <b>Hypertension</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Jonesville</b>		(County) (State)	
21. I certify that I attended the deceased from <b>9/29/1959</b> to <b>10/8/1959</b> , that I last saw the deceased alive on <b>10/8</b> , 19 <b>59</b> , and that death occurred at <b>7:50 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED											
ACTUAL SIGNATURE <b>L. I. Leal</b>				M.D. <b>GAITHERSBURG, MARYLAND</b>							
PHYSICIAN'S NAME (Type) <b>L. I. LEAL, M. D.</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>10-11-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>McConnell</b>		22d. LOCATION (City, town, or county) (State) <b>Jonesville Va</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest C. Gartner, Gaithersburg, Md.</b>						24a. REC'D BY REGISTRAR DATE <b>OCT 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur A. Frank</b>			



Item 21 FilmG250 10-20-59 et

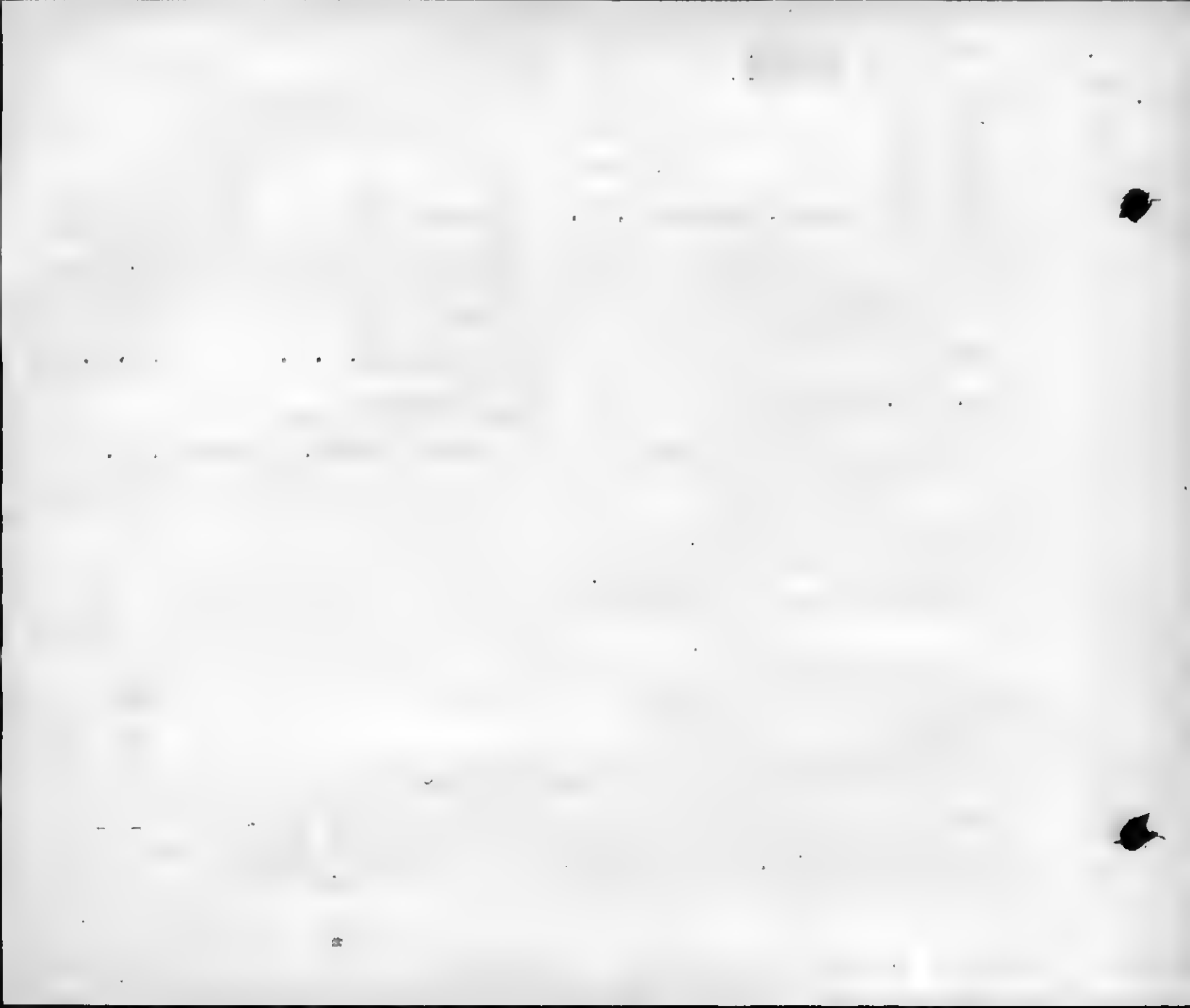
# CERTIFICATE OF DEATH

11593

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>124 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Virginia</b>		b. COUNTY <b>Fairfax</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS <b>Route 5, Box 382</b>	
3. NAME OF DECEASED (Type or print)		First <b>Allan</b>		Middle <b>Lambert</b>		Last <b>McCorkle</b>		4. DATE OF DEATH Month <b>October</b>	
5 SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 6, 1942</b>		9. AGE (In years last birthday) yrs. <b>17</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		10c. IF UNDER 1 YEAR Months <b>10</b>	
13. FATHER'S NAME <b>William E. McCorkle</b>		14. MOTHER'S MAIDEN NAME <b>Inez Lambert</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>The Medical Record</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Center Failure</b> <b>OXYX</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Congestive Heart Failure</b> DUE TO (c) <b>Myocarditis, Mumps ?</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1-2 days</b> <b>7 months</b> <b>7-8 months</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 8, 1959</b> , to <b>October 10, 1959</b> , that I last saw the deceased alive on <b>October 10, 1959</b> , and that death occurred <b>8:50 p.m.</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>9450 p.m. The Clinical Center</b>		DATE SIGNED <b>10-11-59</b>		ACTUAL SIGNATURE <b>Charles A. Chidsey</b>		PHYSICIAN'S NAME (Type) <b>CHARLES A. CHIDSEY, III, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-14-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) <b>Prince George Co., Md.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>Oct 17 1959</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>		24c. REGISTRAR'S NAME <b>Arthur L. Hume</b>		24d. REGISTRAR'S ADDRESS <b>1001 17th St. N.W., Washington, D.C.</b>		24e. REGISTRAR'S PHONE <b>222-1111</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11630

## CERTIFICATE OF DEATH

Reg. Dist. No.

11594  
215

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>26 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>				2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>1812 "K" Street N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Robert Francis MC DERMOTT</b>				4. DATE OF DEATH Month Day Year <b>October 17 1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-10-15</b>	9. AGE (In years last birthday) <b>44</b> yrs	10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>News Press</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Leo MC DERMOTT</b>				14. MOTHER'S MAIDEN NAME <b>Mary Hora</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>WW II</b>		INFORMANT Address <b>(Wife) Claudia McDermott Same as #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic Carcinoma</b> <b>162.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>21 Sept 1959</b> to <b>17 October 1959</b> that I last saw the deceased alive on <b>17 October 1959</b> , and that death occurred at <b>8:48 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda Md. 10-17-59</b>							
ACTUAL SIGNATURE <b>B.C. JOHNSON</b>		M.D. <b>U.S. Naval Hospital, Bethesda Md.</b>					
PHYSICIAN'S NAME (Type) <b>B.C. JOHNSON ICDR MC USN</b>		U.S. Naval Hospital, Bethesda Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-21-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Gawlers</b>			24a. REC'D BY REGISTRAR <b>1756 Penn. Ave. Washington D.C.</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>			



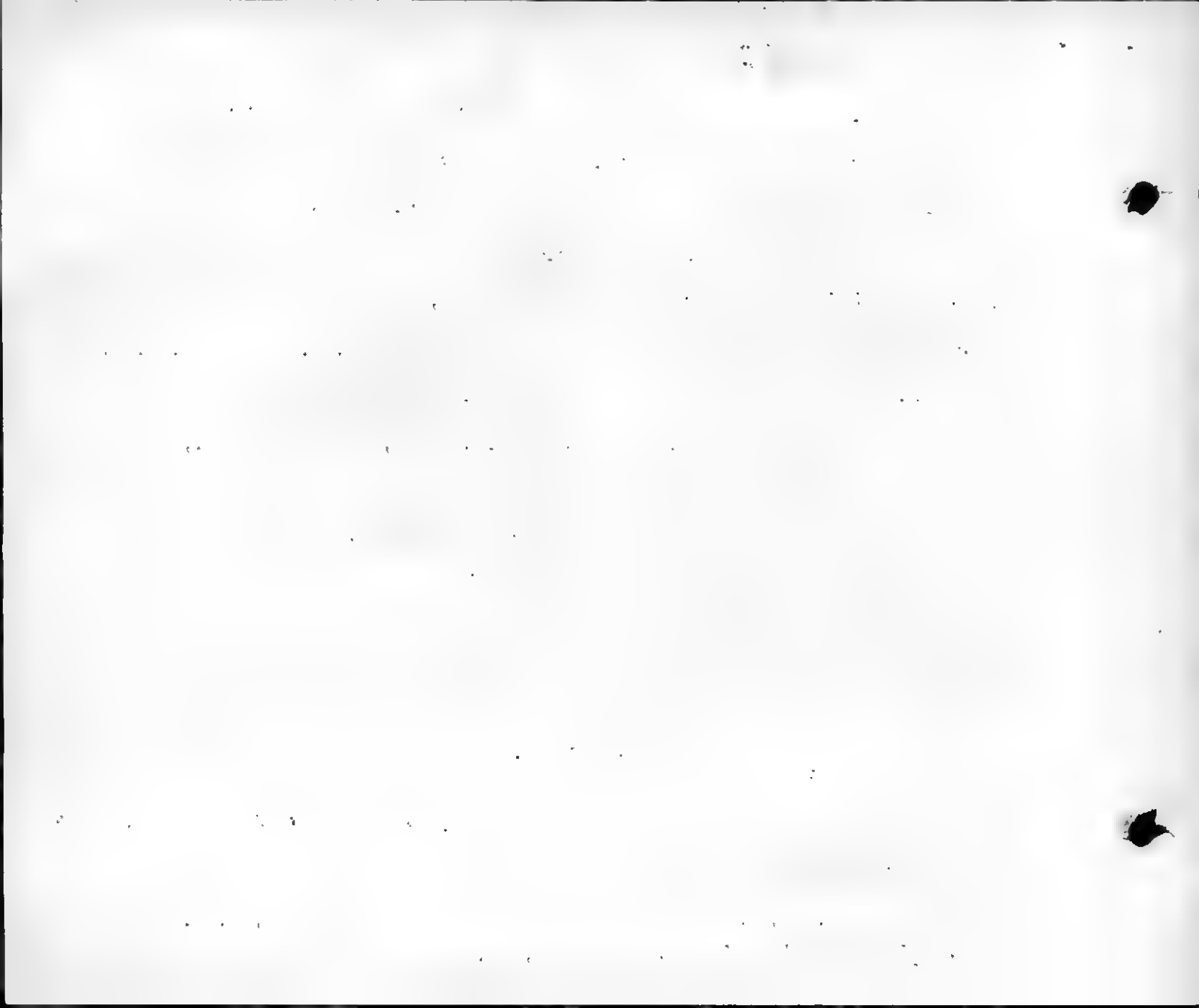


11631

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. LENGTH OF STAY IN 1b <b>12 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7905 TAKOMA AVENUE</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>LUCY</b> Middle <b>G.</b> Last <b>McDONNELL</b>				4. DATE OF DEATH Month <b>OCTOBER 18</b> Day <b>19</b> Year <b>59</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 28, 1881</b>	
9. AGE (In years last birthday) <b>78</b> yrs		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>15</b> Hours <b>15</b> Min.		11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D. C.</b>	
13. FATHER'S NAME <b>JAMES B. EVANS</b>				14. MOTHER'S MAIDEN NAME <b>MARY ANN <del>McDONNELL</del> McCANNA</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>			
17. INFORMANT <b>JOHN E. SIMMONS, 7905 TAKOMA AVE., SILVER SPRING</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>151X</b> DUE TO <b>Incontinence</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of stomach</b> DUE TO <b>1 yr.</b>							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Sept 20, 1959</b> to <b>Oct 18, 1959</b> , that I last saw the deceased alive on <b>Oct 17, 1959</b> , and that death occurred at <b>9:15 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Donald Nelson</b>				ADDRESS (Street, city or town, state) <b>10620 Georgia Ave., Silver Spring, Md.</b>			
PHYSICIAN'S NAME (Type) <b>DONALD NELSON</b>				DATE SIGNED <b>10/19/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>OCT. 21, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D. C.</b>	
23. FUNERAL DIRECTOR'S NAME AND ADDRESS <b>WARNER E. PUMPHREY, INC. Raymond A. Ziska</b>				24a. REC'D BY REGISTRAR <b>OCT 20 59</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>							



11632

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1 PLACE OF DEATH a COUNTY <b>Montgomery</b> b CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c LENGTH OF STAY IN 1b <b>57 days</b>		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a STATE <b>South Carolina</b> b COUNTY <b>Columbia</b> c CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>7</b>	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>		d STREET ADDRESS <b>4115 Bee Clift Drive</b> e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Patrick Lawrence MC NALLY</b>		4 DATE OF DEATH Month Day Year <b>October 5 1959</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>12-21-04</b>
9 AGE (In years last birthday) <b>54 yrs.</b>		10 IF UNDER 1 YEAR Months Days Hours Min. <b>54</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Navy</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Government</b>	
11 BIRTHPLACE (State or foreign country) <b>Georgia</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13 FATHER'S NAME <b>Thomas MC NALLY</b>		14 MOTHER'S MAIDEN NAME <b>Agnes ALLEN</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes 1937 to 40</b>		16 SOCIAL SECURITY NO. <b>577-26-5047</b>	
17 INFORMANT <b>Official hospital records)</b>		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>myocardial infarct</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary atherosclerosis</b> DUE TO <b>Coronary atherosclerosis</b> (c) <b>10 yrs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I attended the deceased from <b>9 August 1959</b> to <b>5 October 1959</b> that I last saw the deceased alive on <b>5 October 1959</b> and that death occurred at <b>2:00PM</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>F.H. O'Connell</b>		ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda Md.</b>	
DATE SIGNED <b>10-5-59</b>			
PHYSICIAN'S NAME (Type) <b>F.H. O'CONNELL LCDR MC USN U.S. Naval Hospital, Bethesda Md.</b>			
22a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b DATE THEREOF <b>10-13-59</b>	
22c NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d LOCATION (City, town, or county) (State) <b>Arlington Va.</b>	
23 FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Bunnell</b>		ADDRESS <b>Wisconsin Bethesda Md.</b>	
24a REC'D BY REGISTRAR <b>OCT 13 '59</b>		24b REGISTRAR'S SIGNATURE <b>Arthur E. Frank</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

185-100-100-100

11633

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>—</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47x-2	
f. STREET ADDRESS <u>2853 Ontario Rd. N.W.</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Helen Alice Morrow</u>		4. DATE OF DEATH Month Day Year <u>Oct 17 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-25-92</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Penn., Bradford</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ned Smith</u>		14. MOTHER'S MAIDEN NAME <u>Whedon, Alta</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>James F. Morrow</u>		Address <u>4809 9 D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO (b) <u>Peritonitis</u> DUE TO (c) <u>Acute suppurative appendicitis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>approx 4 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 14</u> , 1959, to <u>Oct 17</u> , 1959, that I last saw the deceased alive on <u>Oct 16</u> , 1959, and that death occurred at <u>3:50</u> P.M. from the causes and on the date stated above.		ADDRESS (Street, City or town, state) DATE SIGNED	
SIGNATURE <u>George Sharpe m.o.</u> M.D. <u>10511 SUMMIT AVE KENSINGTON</u>		Md.	
PHYSICIAN'S NAME (Type) <u>George SHARPE</u>		<u>10511 Summit Ave Kensington Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>Oct. 19 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>	22d. LOCATION (City, town, or county) (State) <u>Bladensburg Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS</u>		ADDRESS <u>1400 Chapin St N.W. Wash</u>	
24a. REC'D BY REGISTRAR <u>OCT 20 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kane</u>	

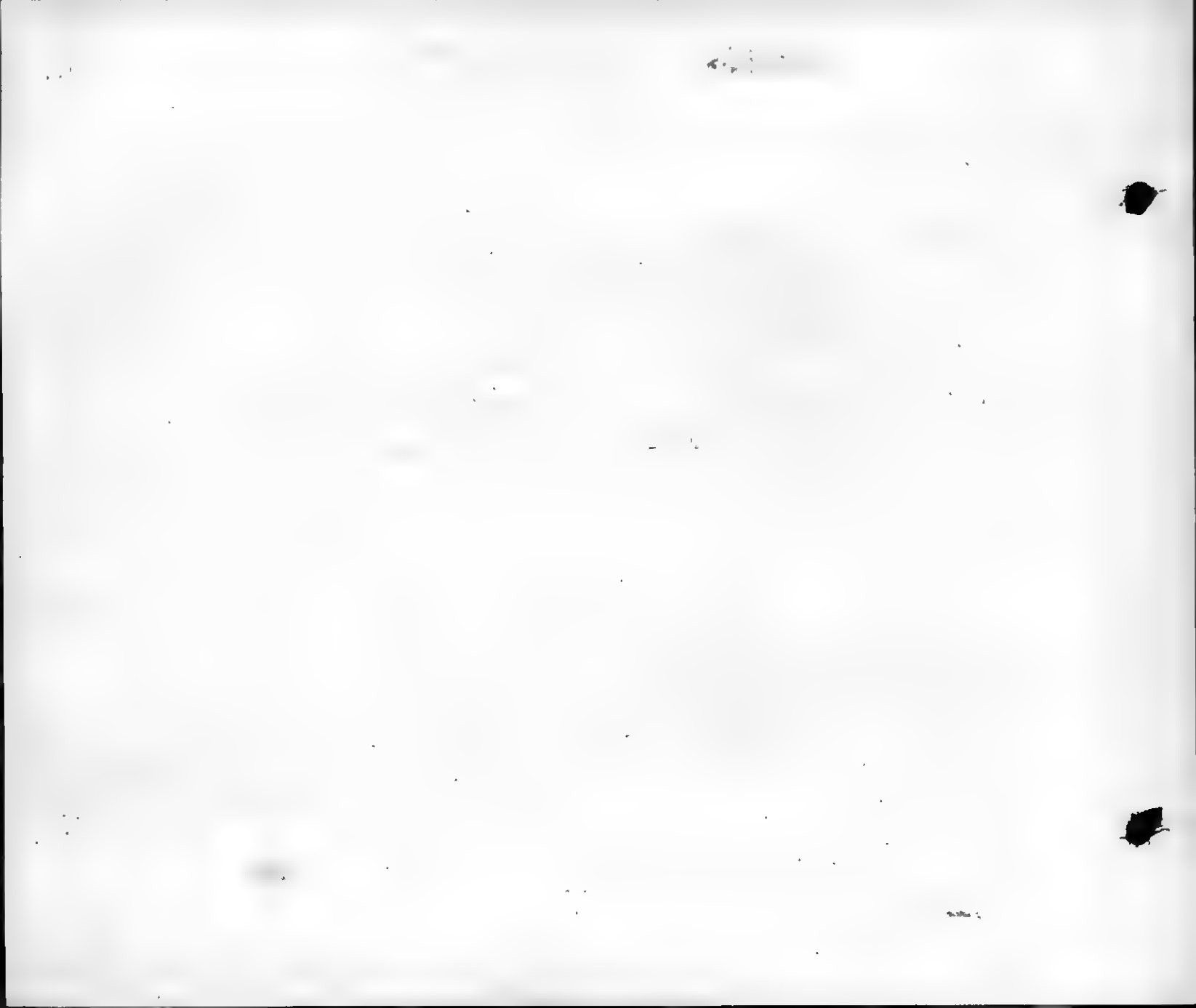
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074

VS A15 (4)  
15M 9/58

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11634

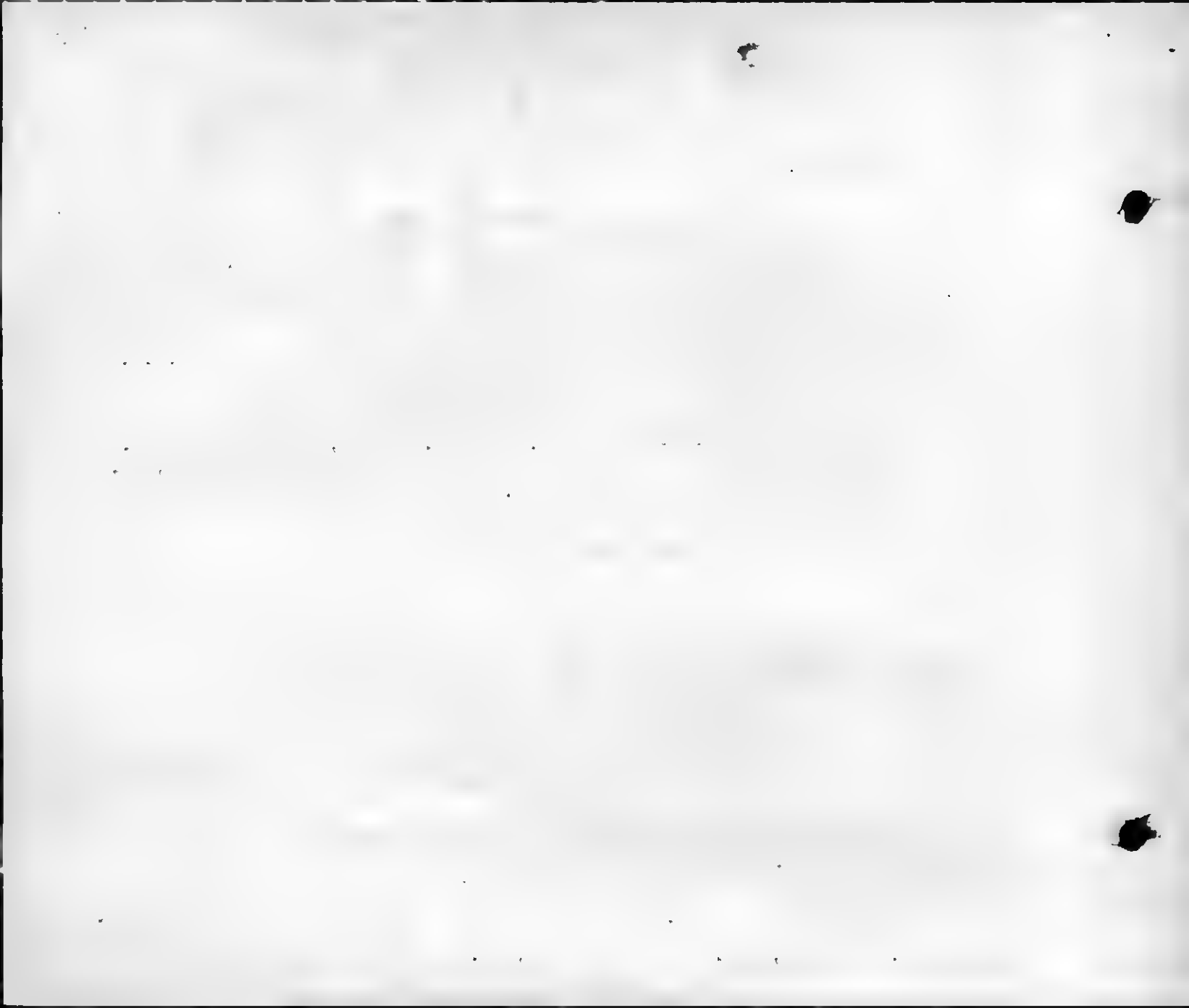
## CERTIFICATE OF DEATH

## 11598

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
c. LENGTH OF STAY IN 1b <b>7 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2211 Seminary Road</b>		d. STREET ADDRESS <b>2211 Seminary Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ALFRED</b> Middle <b>STEVEN</b> Last <b>MERRELL</b>		4. DATE OF DEATH Month <b>OCT.</b> Day <b>30</b> Year <b>19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/11/82</b>
9. AGE (In years last birthday) <b>77</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk (retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery Store</b>	
11. BIRTHPLACE (State or foreign country) <b>Connecticut</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>STEVEN MERRELL</b>		14. MOTHER'S MAIDEN NAME <b>LORETTA JANE MASON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO <b>212-18-8235</b>	
17. INFORMANT <b>Mrs. Helen M. Murphy, 2211 Seminary Rd.</b>		Address <b>Silver Spring, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Decompensation</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10/23</b> 19 <b>59</b> to <b>10/30</b> 19 <b>59</b> , that I last saw the deceased alive on <b>10/28</b> 19 <b>59</b> , and that death occurred at <b>11 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William D. Aud</b> M.D.		ADDRESS (Street, city or town, state) <b>9006 Lakeside Rd, Silver Spring, Md.</b> DATE SIGNED <b>10/30/59</b>	
PHYSICIAN'S NAME (Type) <b>WILLIAM D. AUD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>11/2/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>PRINCE GEORGE COUNTY, MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. Huska</b>		24a. REC'D BY REGISTRAR <b>NOV 3 59</b> DATE	
24b. REGISTRAR'S SIGNATURE <b>C. M. S. Farnes</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
11635  
CERTIFICATE OF DEATH

11599

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. LENGTH OF STAY IN lb <b>Bethesda</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Gardens Sanit.</b> <b>3000 McComas Avenue</b>		e. STREET ADDRESS <b>6010 Sonoma Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Carrie</b> Middle <b>D.</b> Last <b>Merrick</b>		4. DATE OF DEATH Month <b>October</b> Day <b>5</b> Year <b>1959</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/17/1875</b>
9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Dudley</b>		14. MOTHER'S MAIDEN NAME <b>Rachael Thomas</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>no</b>	
17. INFORMANT <b>Records at Kensington Gardens Sanit.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>4-20-0</b> DUE TO <b>Generalized Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Generalized Arteriosclerosis</b> (c) <b>Generalized Arteriosclerosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Serious Arteriosclerosis</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 10-5-1959</b> to <b>Oct 5 1959</b> , that I last saw the deceased alive on <b>10-5-1959</b> , and that death occurred at <b>11:25 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4201 Fessenden St N.W. 10-639</b> DATE SIGNED <b>P.P. Andrews</b> ACTUAL SIGNATURE <b>P.P. Andrews</b> M.D. <b>Washington D.C.</b> PHYSICIAN'S NAME (Type) <b>P.P. ANDREWS M.D. Washington D.C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>10/6/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sudlersville</b>		22d. LOCATION (City, town, or county) (State) <b>Sudlersville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b> ADDRESS <b>Wash. D.C.</b>		24a. REG'D BY REGISTRAR <b>OCT 6 1959</b> DATE	
24b. REGISTRAR'S SIGNATURE <b>Arthur A. Hines</b>			

710

11636

CERTIFICATE OF DEATH

11630

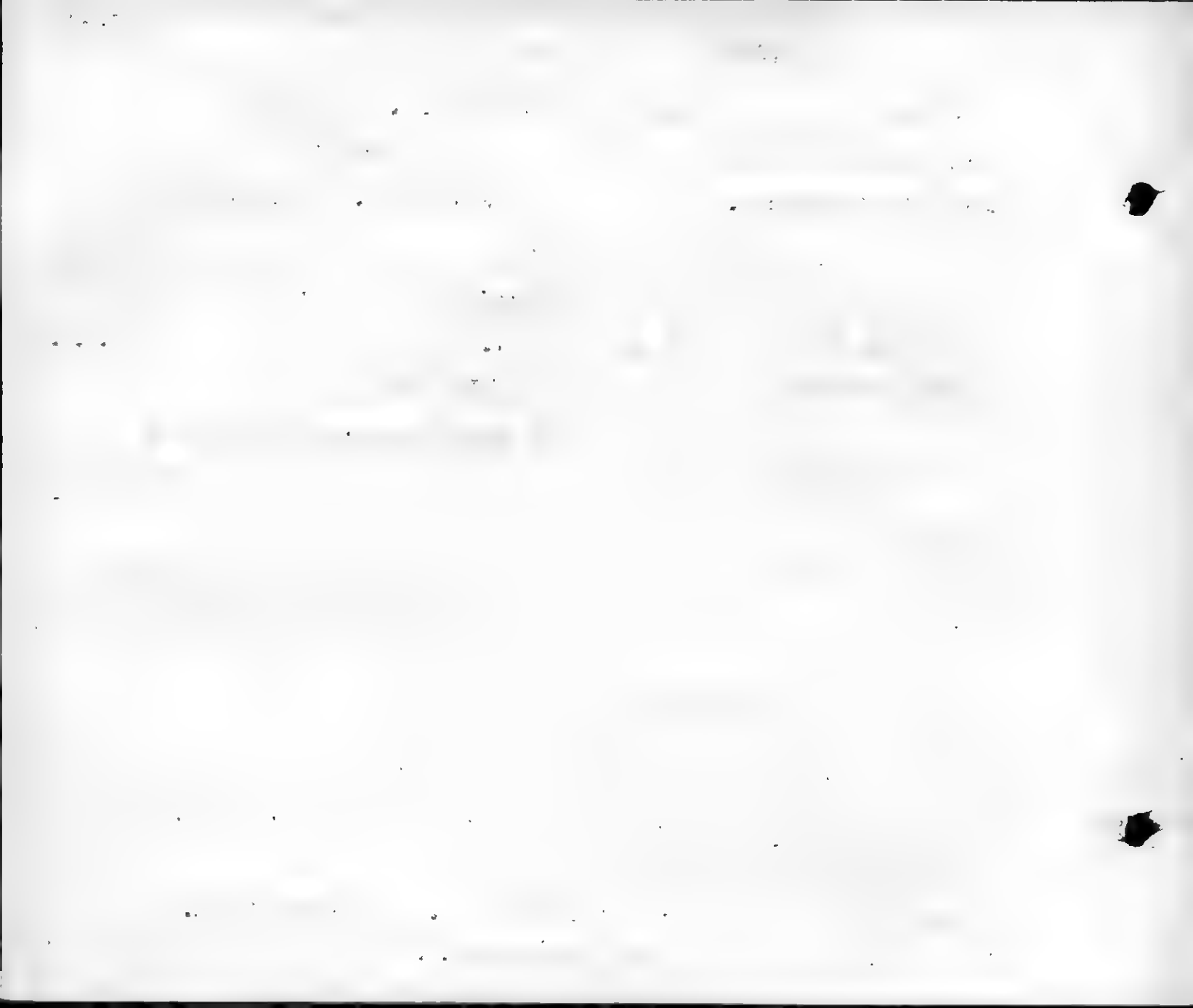
Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MD MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <b>SILVER SPRING MD</b>	
b CITY OR TOWN (if outside corporate limits, write RURAL, and give nearest town) <b>KENSINGTON MD</b>		c CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING MD</b>	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>KENSINGTON GARDENS SAN.</b>		e STREET ADDRESS <b>834 GIST AVE. SILVER SPRING MD</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>VIOLA V MEYER'S</b>		4. DATE OF DEATH Month Day Year <b>Oct 1 1959</b>	
5. SEX <b>FEM</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/23/1880</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>V. VA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOSEPH E SHRIVER</b>		14. MOTHER'S MAIDEN NAME <b>ELIZA WEIGLE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>MRS FRIDA E GREENTHER SILVER SP MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma, Breast, recurrent</b> 170 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension Heart Dis. Tuberculosis Pres. arrested.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>002 X</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>19 42 p.m. Oct. 1</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Oct 1</b> , 19 <b>59</b> , and that death occurred at <b>8:50 p.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>M.D. 13000 GEORGIA AVE - S.I. P. MD.</b>			
ACTUAL SIGNATURE <b>S. L. TABB, M.D.</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>10/5/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>PROVIDENCE CHURCH CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>LEDGESVILLE W VA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. H. Smithman Son</b>		24a. REC'D BY REGISTRAR <b>OCT 5 2 '59</b>	
ADDRESS <b>5732 GEORGIA AVE N.W.</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Smithman</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



11637

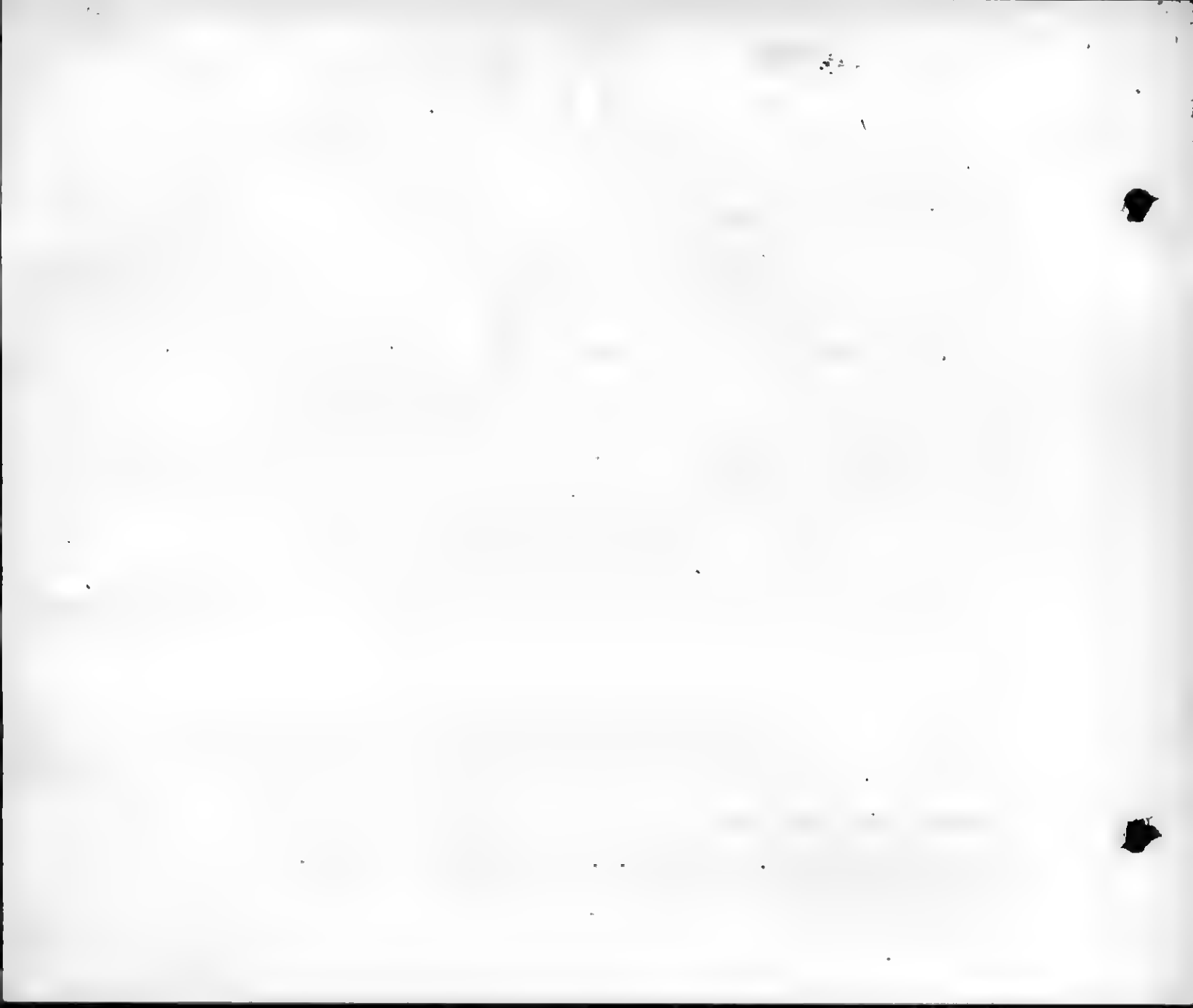
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>26 Rockville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rest Haven Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>L</b> Last <b>Mills</b>		4. DATE OF DEATH Month <b>10</b> Day <b>6</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/17/64</b>
9. AGE (In years last birthday) <b>94</b> yrs.		IF UNDER 1 YEAR: Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Track Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>US</b>		13. FATHER'S NAME <b>John Mills</b>	
14. MOTHER'S MAIDEN NAME <b>Martha Day</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>Sadie Johnson-daughter-same as 2d</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>Cerebral Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) <b>Arteriosclerotic C.V. Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>Indef.</b> <b>Indef.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Operation 2 wks. ago for Enlarged Heart</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2/1</b> , 19 <b>57</b> , to <b>10/6</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>10/6</b> , 19 <b>59</b> , and that death occurred at <b>12:45 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stephen N. Jones</b> M.D.		ADDRESS (Street, city or town, state) <b>Rockville, Md.</b> DATE SIGNED <b>10/6/59</b>	
PHYSICIAN'S NAME (Type) <b>Stephen N. Jones, M.D.</b>		<b>Rockville, Md.</b>	
22a. BURIAL, CREMAT. OR REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/8/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rockville Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR <b>OCT 7 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 11638 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

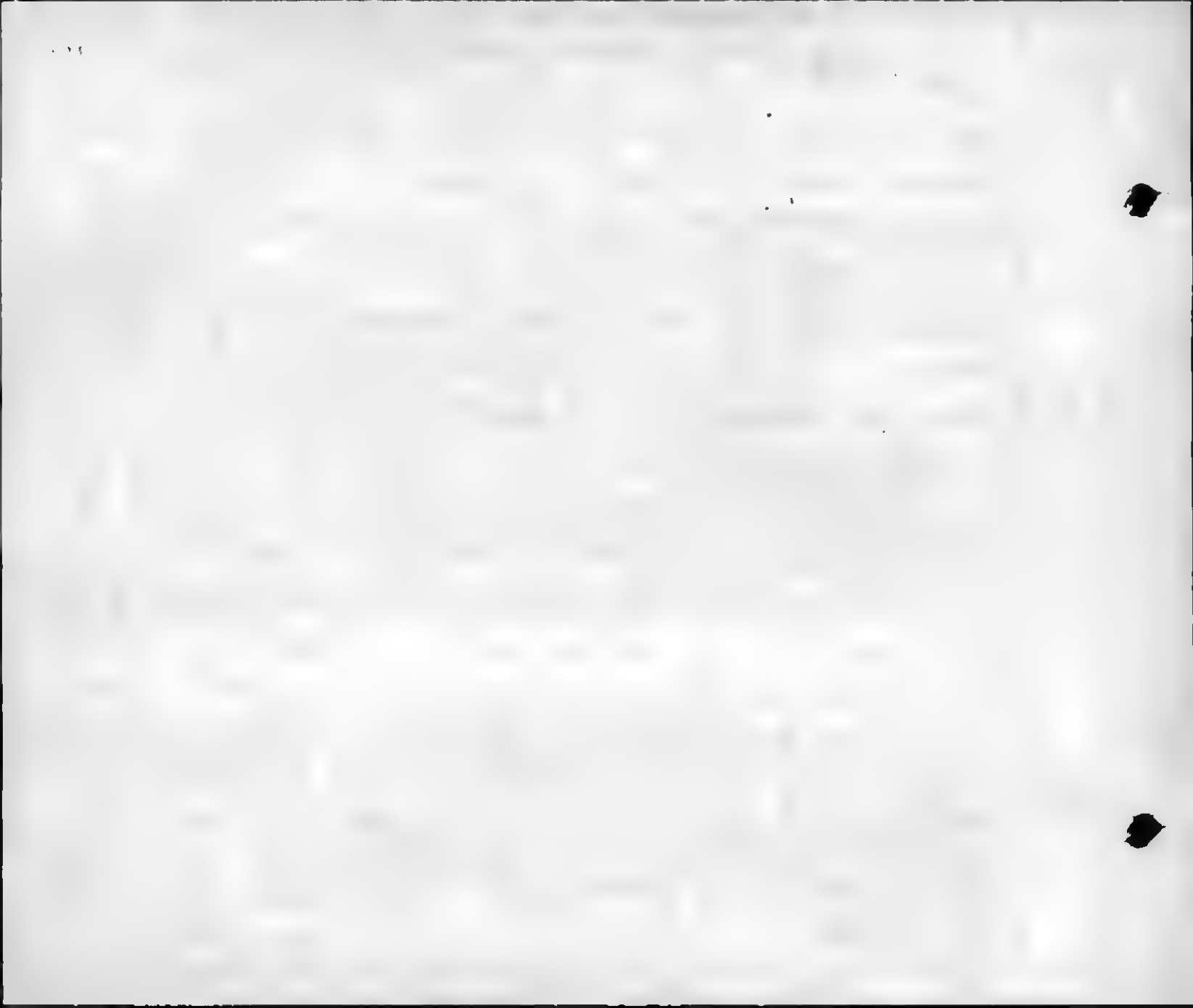
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7 Cedar Ave</u>		d. STREET ADDRESS <u>7 Cedar Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Laveta</u> Middle <u>Mary</u> Last <u>Mills</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>17</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-2-1894</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>John T. Martin</u>		14. MOTHER'S MAIDEN NAME <u>Emma M. Spater</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Ralph Mills - Son</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>10-20-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>		22d. LOCATION (City, town, or county) (State) <u>Gaithersburg Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Partner</u>		ADDRESS <u>Gaithersburg Md</u>	
24a. REC'D BY REGISTRAR <u>OCT 20 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Hand</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





## CERTIFICATE OF DEATH

Reg. Dist. No.

11516

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Hyattsville</u>	
c. LENGTH OF STAY IN 1b <u>12 mins.</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hospital</u>	
d. STREET ADDRESS <u>1400 East West Hwy</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lawrence Edward Morgans</u>		4. DATE OF DEATH Month Day Year <u>October 7 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-18-20</u>
9. AGE (In years last birthday) <u>39</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Security Guard</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Penna</u>	
11. BIRTHPLACE (State or foreign country) <u>Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Vincent B. Morgans</u>		14. MOTHER'S MAIDEN NAME <u>Helen Kusky</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>2nd W.W.</u>	
17. INFORMANT <u>Mrs. Ruby H. Morgans - wife</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>acute</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 7</u> , 19 <u>59</u> , to <u>Oct 7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct 7</u> , 19 <u>59</u> , and that death occurred at <u>6:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>10/7/59</u>			
ACTUAL SIGNATURE <u>Ernest A. Sarao</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Ernest A. Sarao</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Oct 10-1959</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Fl. Lincoln</u>		22d. LOCATION (City, town, or county) <u>Adamsburg Road Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>		ADDRESS <u>254 Carroll St NW, DC</u>	
24a. REC'D BY REGISTRAR DATE <u>OCT 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11517 CERTIFICATE OF DEATH

11604

Reg. Dist. No.

<b>1 PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span>				<b>2 USUAL RESIDENCE</b> (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Montgomery</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San &amp; Hosp.</u>				d. STREET ADDRESS <u>16409 Eastern Ave</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Perminia</u> <u>Claude</u> <u>Morris</u>				<b>4. DATE OF DEATH</b> Month <u>Oct.</u> Day <u>15</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/18/08</u>	9. AGE (In years last birthday) <u>51</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shop Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Charles B Morris</u>				
14. MOTHER'S MAIDEN NAME <u>Maude Shifflett</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				
16. SOCIAL SECURITY NO <u>214 01 0263</u>			INFORMANT <u>Hosp H</u>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage severe</u> <u>330X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Lobar pneumonia rt lower lobe</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month. Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from <u>10-12</u> , 19 <u>59</u> , to <u>10-15</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10-15</u> , 19 <u>59</u> , and that death occurred at <u>11:50 A.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>5600 N. H. Ave., WASH. DC.</u> DATE SIGNED <u>10/15/59</u>							
ACTUAL SIGNATURE <u>Samuel M. Bageant</u> M.D.							
PHYSICIAN'S NAME (Type) <u>SAMUEL M. BAGEANT</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Oct. 19, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>			
22d. LOCATION (City, town, or county) (State) <u>Prince George's County, Md.</u>		24a. REC'D BY REGISTRAR <u>1959</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Kraus</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters, 254 Carroll St NW DC</u>							

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

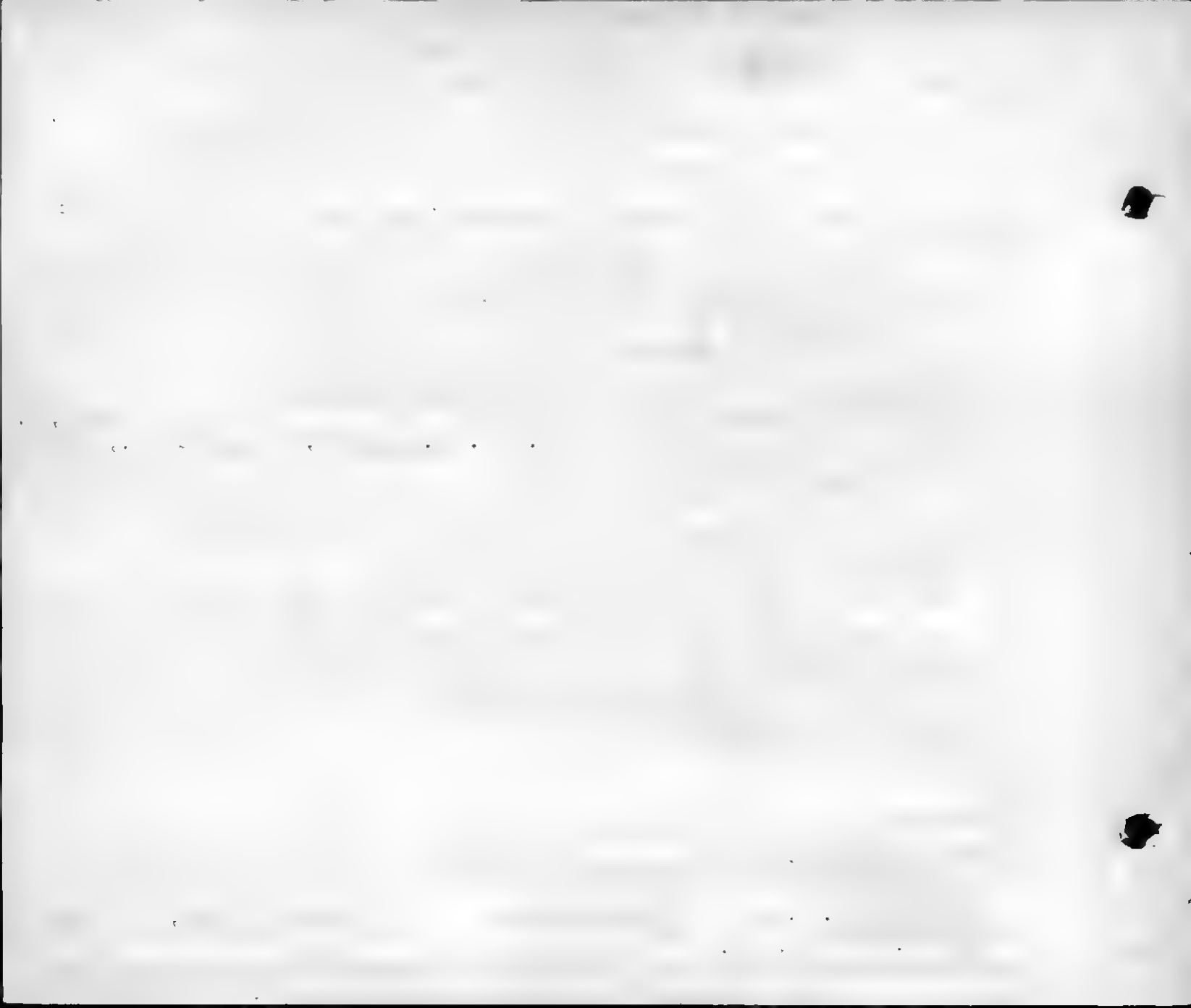
11639

## CERTIFICATE OF DEATH

Reg. Dist. No.

11605

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FAIRLAND</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FAIRLAND NURSING HOME</u>				d. STREET ADDRESS <u>11307 Amherst Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LAURA</u> Middle <u>MAX</u> Last <u>MUNDY</u>				4. DATE OF DEATH Month <u>10</u> Day <u>16</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 26, 1888</u>	
9. AGE (In years last birthday) <u>71</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>W. VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Patrick Mundy</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Geo. Wm. Kerns</u>		Address <u>11,307 Amherst Ave., Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> 1 <u>2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adeno-carcinoma Right Maxillary Sinus</u> DUE TO (c) <u>Pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. 7</u> Month <u>  </u> Day <u>  </u> Year <u>19</u> p. m. <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>							
21. I certify that I attended the deceased from <u>Sept. 1959</u> to <u>16 Oct. 1959</u> , that I last saw the deceased alive on <u>7 Oct. 1959</u> , and that death occurred at <u>10:15 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Merton L. White</u> M.D. <u>11134 Georgia Ave Silver Spring Md 16 Oct 59</u>				ADDRESS (Street, city or town, state) <u>  </u> DATE SIGNED <u>  </u>			
PHYSICIAN'S NAME (Type) <u>MERTON L. WHITE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 19, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC., SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	
DATE <u>Oct 20 1959</u>							



1  
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

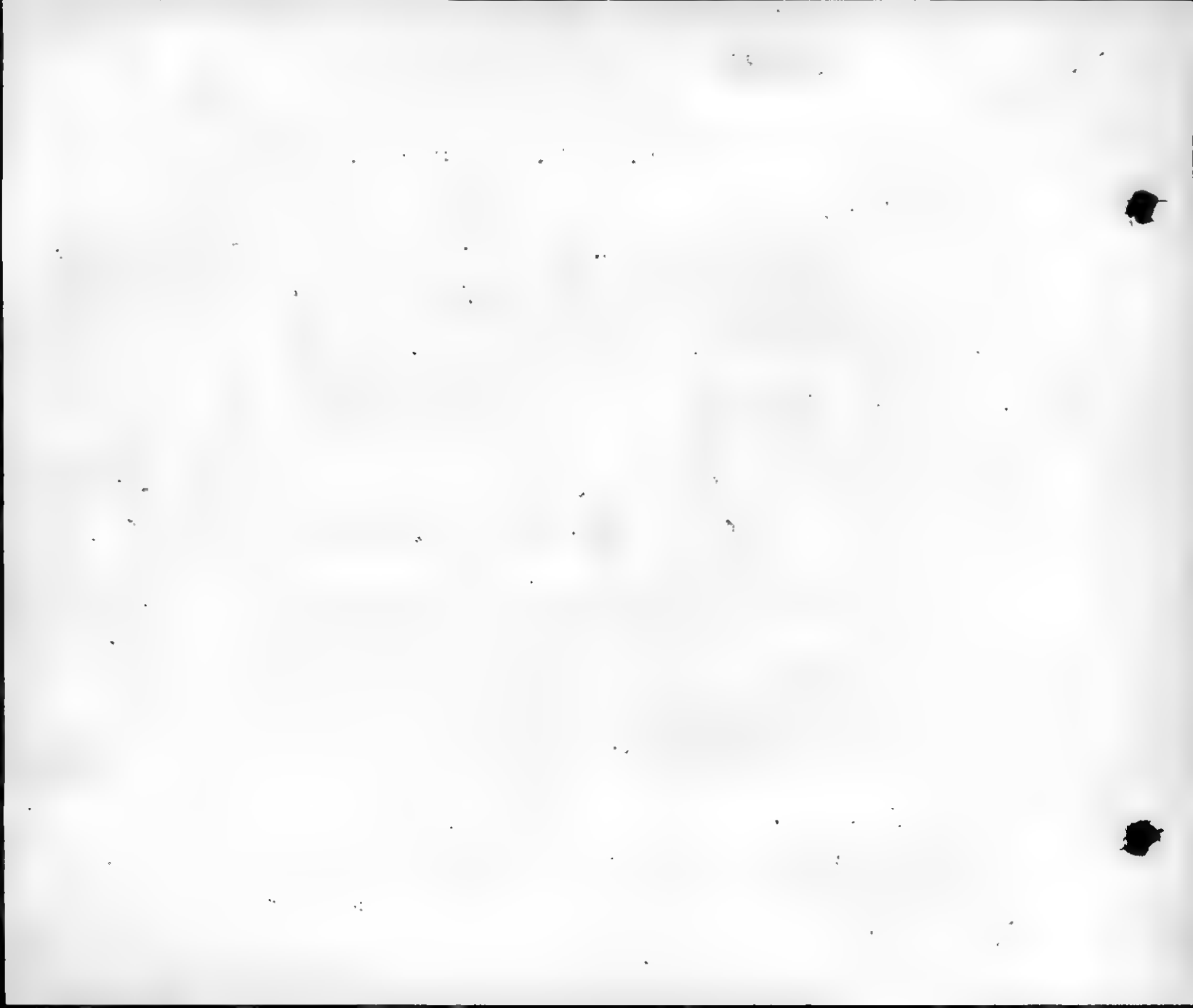
11608

11640

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>4 hrs. 10 min.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>A.</b> Last <b>Myer</b>		4. DATE OF DEATH Month <b>10</b> Day <b>20</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/16/05</b>
9. AGE (In years last birthday) <b>54</b> yrs		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>20</b> Hours <b>10</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Edward A. Myer</b>		14. MOTHER'S MAIDEN NAME <b>Doris Russell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>No</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Exsanguination</b> 581.0 DUE TO <b>Bleeding gastro-esophageal Varices</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO <b>Cirrhosis of liver</b> (b) <b>Cirrhosis of liver</b> (c) <b>Cirrhosis of liver</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Days 2</b> <b>Years 2</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <b>Edwards Myer's medical father</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 17</b> , 19 <b>57</b> , to <b>OCT 20</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>OCT 20</b> , 19 <b>59</b> , and that death occurred at <b>2:15</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Washington, D.C.</b> DATE SIGNED <b>10/21/59</b> ACTUAL SIGNATURE <b>Michel M. Healy</b> M.D. <b>Washington Clinic, Wash., D.C.</b> PHYSICIAN'S NAME (Type) <b>MICHEL M. HEALY</b> WASHINGTON CLINIC, WASH., D. C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>10-23-1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington NATIONAL</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Hawley's Sons, Wash., D.C.</b>		24a. REC'D BY REGISTRAR <b>OCT 26 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			





11641

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Madison</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Montgomery Hill</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randolph Hill</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Agnew Memorial Hospital, Ind.</u>				d. STREET ADDRESS <u>4614 Olden Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNA K MYERS</u>				4. DATE OF DEATH Month Day Year <u>Oct 14 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 22 1894</u>	
9. AGE (In years last birthday) <u>65</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>South. Dakota</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Relief</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Gov. Employee</u>			
13. FATHER'S NAME <u>George Knudson</u>				14. MOTHER'S MAIDEN NAME <u>Nana ?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO			
17. INFORMANT <u>Healed Nacio</u>				Address <u>4614 Olden Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral and General arteriosclerosis</u> DUE TO (c) <u>2 + yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetic Mellitus since 1945</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20a. TIME OF INJURY Month Day Year Hour a.m. p.m. <u>19</u>				20c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20e. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>3 Oct 1959</u> to <u>14 Oct 59</u> , that I last saw the deceased alive on <u>13 Oct 1959</u> , and that death occurred at <u>440</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>A.H. Richwine</u> M.D.				<u>5522 Western Ave.</u>			
PHYSICIAN'S NAME (Type) <u>A.H. RICHWINE</u>				<u>Cherry Chase 15, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 17, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Addison Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Seat Pleasant Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deal Funeral Home</u>				ADDRESS <u>4812 He Ave NW</u>			
24a. REC'D BY REGISTRAR DATE <u>OCT 19 59</u>				24b. REGISTRAR'S SIGNATURE <u>William S. Frank</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[illegible]

1887

*[Faint handwritten notes at the bottom of the page, possibly bleed-through from the reverse side.]*

11642

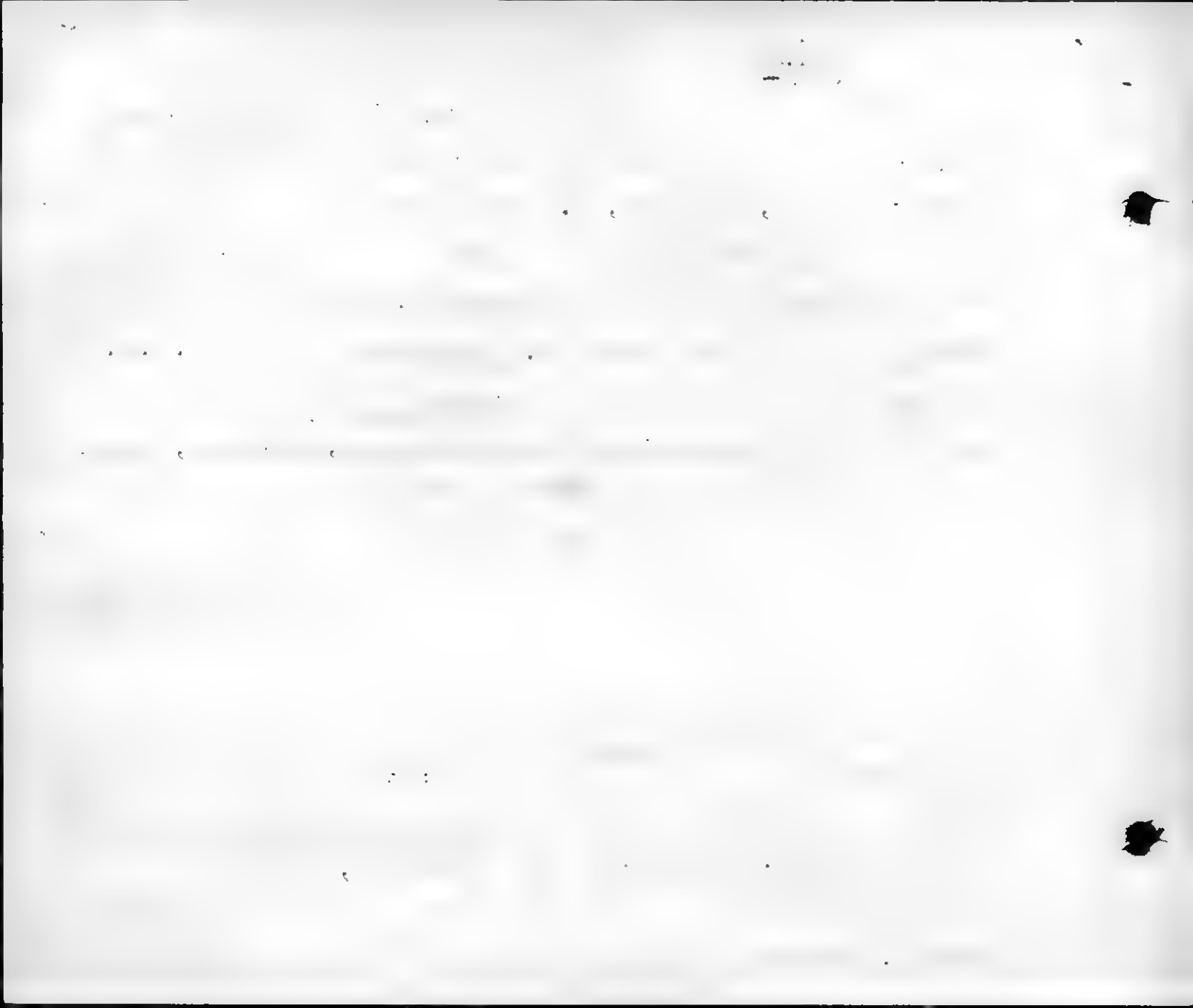
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>6 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>4535 Bennion Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Francis Martin Myers</b>				4. DATE OF DEATH Month Day Year <b>October 18 1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 13, 1925</b>	
9. AGE (In years last birthday) <b>34</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Light &amp; Power Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Ira Myers</b>				14. MOTHER'S MAIDEN NAME <b>Mary Barr</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or dates of service) <b>WW II</b>				16. SOCIAL SECURITY NO <b>Unascertainable</b>			
17. INFORMANT <b>The Medical Record</b>				Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhagic bronchopneumonia</b>							
DUE TO (b) <b>Acute myelogenous leukemia</b>							
DUE TO (c) <b>7 months</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19 WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>October 12, 1959</b> to <b>October 18, 1959</b> , that I last saw the deceased alive on <b>October 18, 1959</b> , and that death occurred at <b>12:20 am</b> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>The Clinical Center Bethesda 14, Maryland</b>							
ACTUAL SIGNATURE <i>Jerry S. Trier</i>				DATE SIGNED <b>10-18-59</b>			
PHYSICIAN'S NAME (Type) <b>Jerry S. Trier, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-transit</b>		22b. DATE THEREOF <b>10/22/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Quarryville Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Quarryville, Pennsylvania</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>				24a. REC'D BY REGISTRAR <b>OCT 23 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the other papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11643

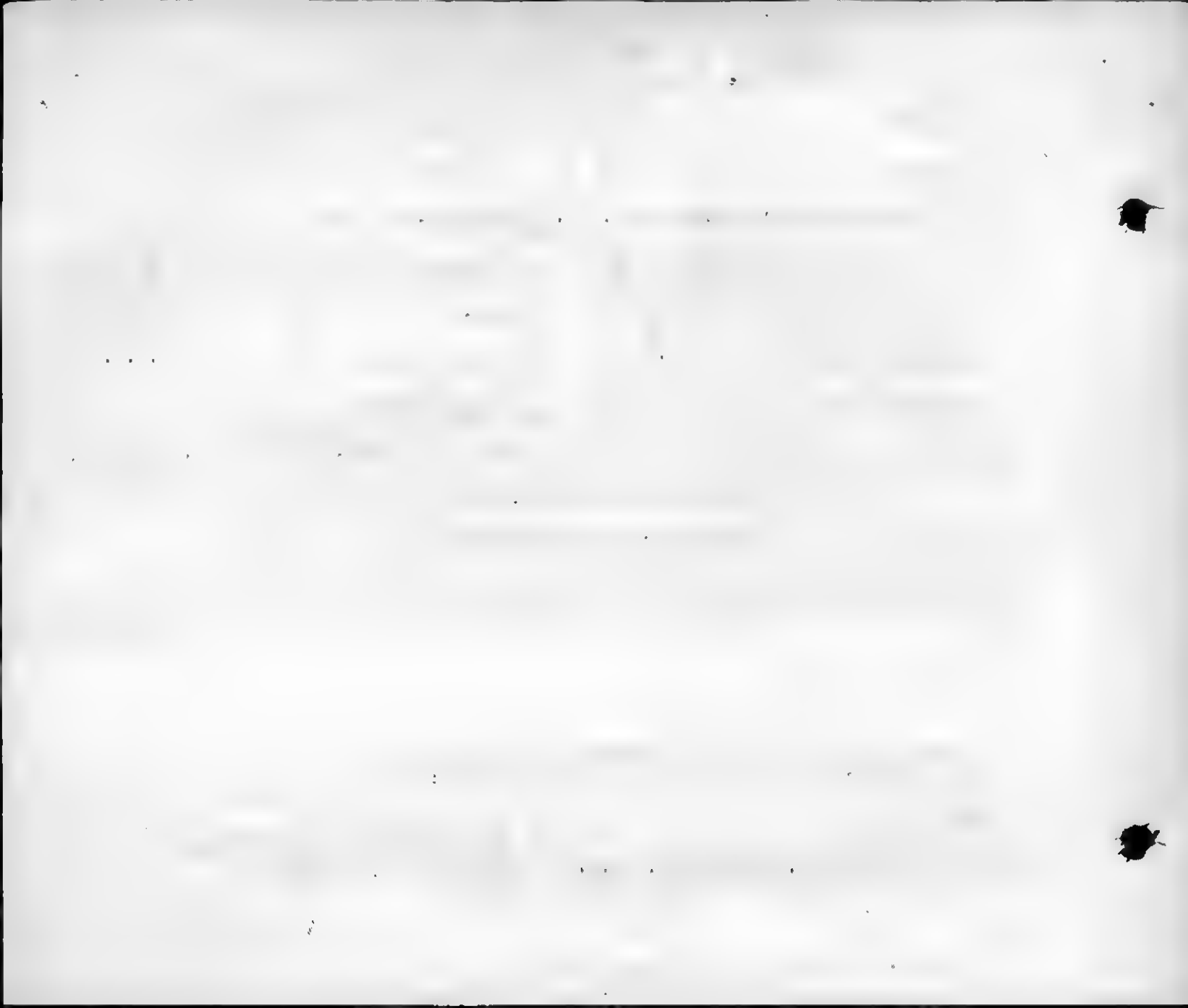
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Alabama</b> b. COUNTY <b>Jefferson</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>20 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bessemer</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>			d. STREET ADDRESS <b>Route 3, Box 894</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Ada</b> Middle <b>Mae</b> Last <b>Naish</b>			4. DATE OF DEATH Month <b>October</b> Day <b>4</b> Year <b>19 59</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 1, 1896</b>		9. AGE (In years last birthday) <b>63</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Alabama</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Greenburg Seale</b>			14. MOTHER'S MAIDEN NAME <b>Maude Brasher</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bilateral bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Amyotrophic lateral sclerosis</b> DUE TO (c)					INTERVA. BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>September 14, 19 59</b> , to <b>October 4, 19 59</b> , that I last saw the deceased alive on <b>October 4, 19 59</b> , and that death occurred at <b>1:40 A</b> M, from the causes and on the date stated above					
ACTUAL SIGNATURE <b>Donald H. Silberberg, M.D.</b>		ADDRESS (Street, city or town, state) <b>The Clinical Center</b>		DATE SIGNED <b>10/4/59</b>	
PHYSICIAN'S NAME (Type) <b>DONALD H. SILBERBERG, M.D.</b>		<b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit</b>		22b. DATE THEREOF <b>10/4/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Val Halla Cemetery</b>	
				22d. LOCATION (City, town, or county) (State) <b>Bessamer, Alabama</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>			ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>OCT 6 '59</b>
					24b. REGISTRAR'S SIGNATURE <b>C. H. &amp; K. H.</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11610

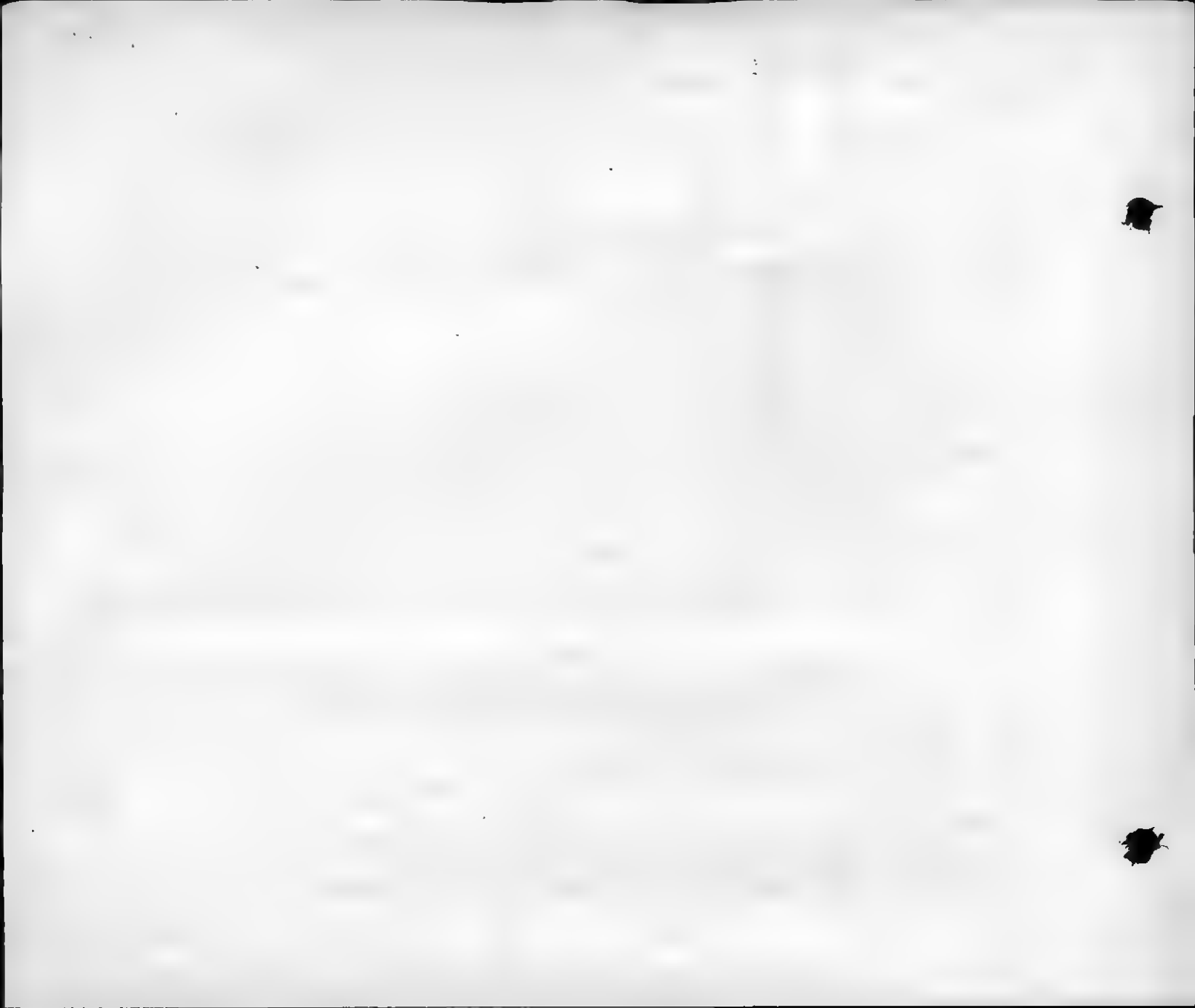
11518

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY in 1b <b>5 mo.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville, Md.</b> d. STREET ADDRESS <b>909 Cox Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Florence Agnes Neitzey</b>		4. DATE OF DEATH Month Day Year <b>10 - 31 - 1959</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-6-91</b>	9. AGE (In years last birthday) <b>67</b> yrs	IF UNDER 1 YEAR: Months Days Hours Min IF UNDER 24 HRS: Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hswnf</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>MARK WARD</b>		14. MOTHER'S MAIDEN NAME <b>Anna Healey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>PH's Hosp. Record</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>carcinoma of pelvic organs metastatic</b> <b>153.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>carcinoma of colon</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>six mos</b> <b>4 yrs</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <b>1955</b> to <b>Oct-31, 1959</b> , that I last saw the deceased alive on <b>Oct-31, 1959</b> , and that death occurred at <b>5:30 P.M.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Robert A. Hare</b>		ADDRESS (Street, city or town, state) <b>7600 Carroll Ave., Tak. Park, Md.</b>		DATE SIGNED <b>10/31/59</b>	
PHYSICIAN'S NAME (Type) <b>Robert A. Hare, MD.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>Nov 4, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN</b>	
22d. LOCATION (City, town, or county) <b>Bladensburg Bur 9, Md.</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Altman</b>		ADDRESS <b>3603 14th St NW</b>		24a. REC'D BY REGISTRAR <b>NOV 2 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Caroline S. Hume</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11519

## CERTIFICATE OF DEATH

11611

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DIST. of Columbia</u> b. COUNTY <u>Washington, D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WILSON PARK</u>		c. LENGTH OF STAY IN TB <u>7 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON, D.C.</u>		47X-E	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington State Hosp. &amp; Inst.</u>		d. STREET ADDRESS <u>441 Constitution St. N.E.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Daniel Aaron Nussbaum</u>		4. DATE OF DEATH Month Day Year <u>10 20 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-2-76</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Spec. Industries</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Spec. Industries</u>	
11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Shafter Nussbaum</u>		14. MOTHER'S MAIDEN NAME <u>Letty Shift</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>—</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>myocardial Infarction (Coronary Occlusion)</u> (c) <u>Hypertensive Arteriosclerotic Cardiovascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>3 hours</u> <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Symptomatic Prostatectomy - 10/21/59</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-3-1952</u> to <u>10/23-1959</u> , that I last saw the deceased alive on <u>10/23-1959</u> , and that death occurred at <u>8:25 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Benjamin Isaacson</u>		ADDRESS (Street, city or town, state) <u>7733 Alaska Ave. N.W. Washington 12 D.C.</u>	
DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Benjamin Isaacson</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>Oct. 23, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. LEBANON CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>HYATTSVILLE MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Danzansky &amp; Sons</u>		ADDRESS <u>301 14th St. N.W.</u>	
DATE <u>OCT 26 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Carl S. Kraus</u>	



11644  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shirley</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>				d. STREET ADDRESS <u>3202 Perry St.</u>			
3. NAME OF DECEASED (Type or print) <u>Mabel</u> First <u>Marion</u> Middle <u>Olwine</u> Last				4. DATE OF DEATH Month <u>Oct.</u> Day <u>5</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 26, 1883</u>	
9. AGE (In years last birthday) <u>76</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>Gloucester Co., Va.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Gilbert F. Shackelford</u>				14. MOTHER'S MAIDEN NAME <u>Mary Wallace</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO			
17. INFORMANT <u>(Bro.) W.B. Shackelford</u>				18. ADDRESS <u>3202 Perry St., Mt. Rainier</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>221X</u> DUE TO <u>Cerebral aneurysm</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral vascular accident</u> DUE TO (c) <u>1 day</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic changes</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>10</u> Day <u>8</u> Year <u>1959</u> Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7-7-1959</u> to <u>10-5-1959</u> , that I last saw the deceased alive on <u>9-17-1959</u> , and that death occurred at <u>6:30</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Roy B. Parsons, Jr.</u> M.D.				DATE SIGNED <u>October 5, 1959</u>			
PHYSICIAN'S NAME (Type) <u>Roy B. Parsons, Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/8/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. J. ...</u> ADDRESS <u>...</u>				24a. REC'D BY REGISTRAR <u>...</u> DATE <u>7-59</u>		24b. REGISTRAR'S SIGNATURE <u>...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



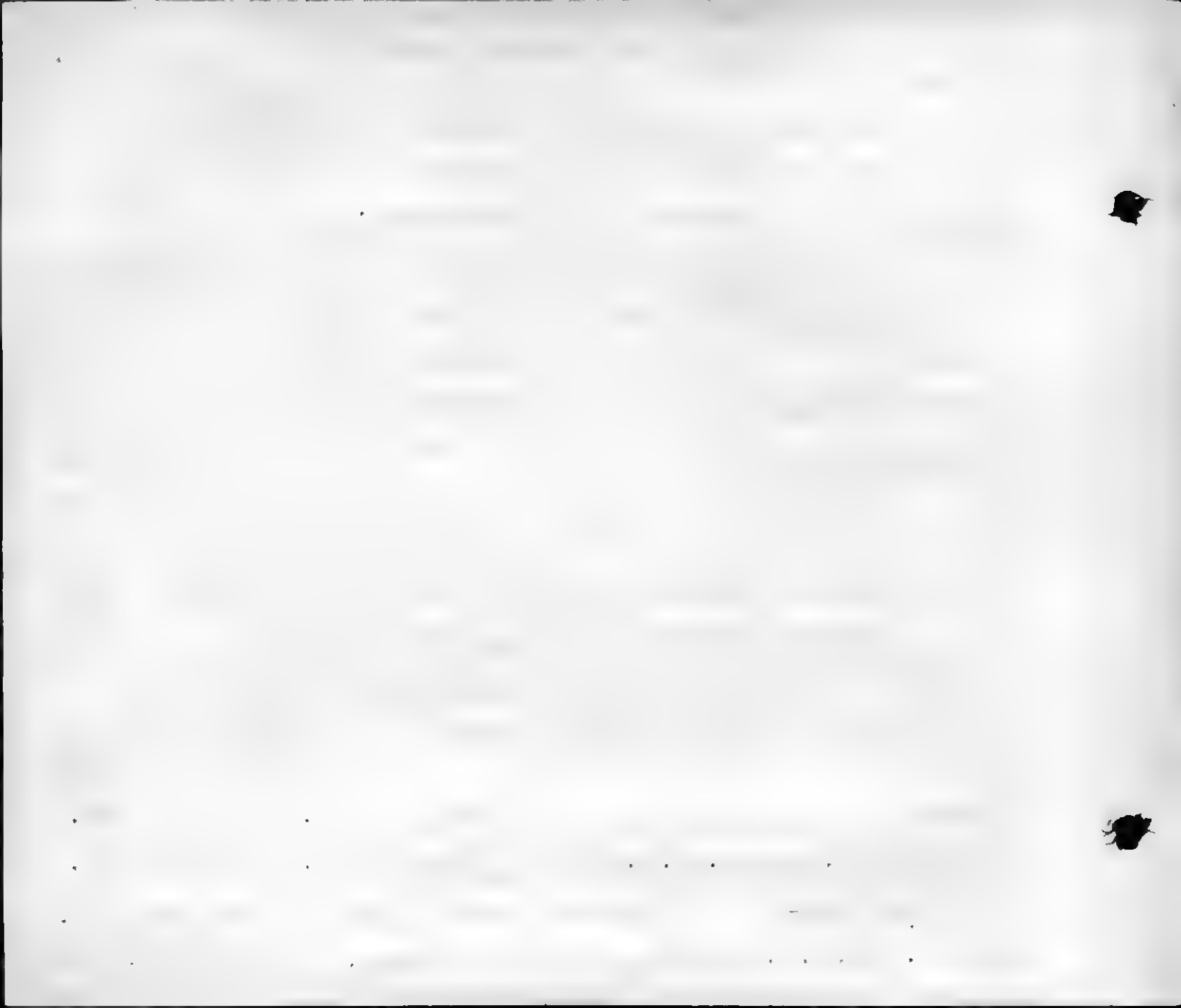
11520

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>		d. STREET ADDRESS <u>33 B Ridge Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Baby Boy</u> First Middle Last		4. DATE OF DEATH <u>10</u> Month <u>16</u> Day <u>1959</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-15-59</u>
9. AGE (In years last birthday) yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min <u>7</u> <u>9</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>no</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>no</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Louis (NMN) Oppermann Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Shirley June Grimes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mother's Chart</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Unconsciously</u>			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>—</u>			
DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>10-15</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6:16 P.M. 10-15, 1959</u> to <u>1:25 AM 10-16, 1959</u> , that I last saw the deceased alive on <u>10-15, 1959</u> , and that death occurred at <u>1:25 A.M.</u> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>918 Ellsworth Dr., Silver Spring, Md.</u> DATE SIGNED			
ACTUAL SIGNATURE <u>Louis H. Moody Jr., M.D.</u> M.D. <u>918 Ellsworth Dr., Silver Spring, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Louis H. Moody Jr., M.D.</u> <u>918 Ellsworth Dr., Silver Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>9-16-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium and Hospital, Takoma Park 12, Md.</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare, M.D.</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Hare</u> 24b. REGISTRAR'S SIGNATURE	
DATE <u>OCT 19 '59</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11645

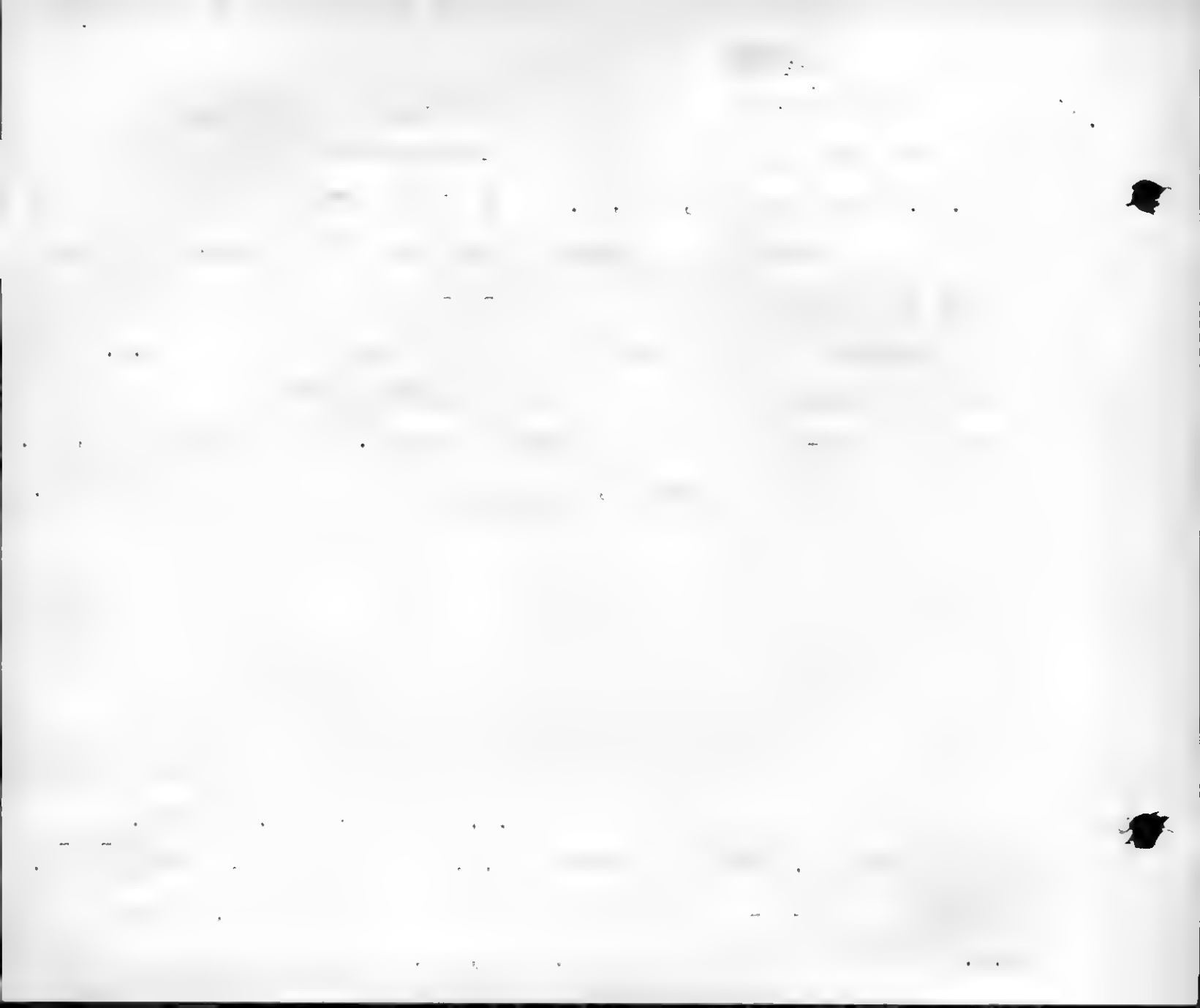
## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admision) o STATE <b>Maryland</b> b. COUNTY <b>St Marys</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>18 days</b>	
d. NAME OF HOSPITAL (If not in hosp ital, give street address) OR INSTITUTION <b>U. S. Naval Hospital, Beth, Md.</b>		e. STREET ADDRESS <b>Lexington Park Hotel</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Marcia Kindred Painter</b>		4. DATE OF DEATH Month Day Year <b>October 12 1959</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-21-28</b>
9. AGE (In years last birthday) <b>31 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Ellis KINDRED</b>		14. MOTHER'S MAIDEN NAME <b>Imogene PATE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1948-1952</b>	
17. INFORMANT <b>(Husband) John L. Painter</b>		Address <b>vw15 USNAS Pax River, Md.</b>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Leukemia, Myelogenous</b> <b>204.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)			INTERVAL BETWEEN ONSET AND DEATH <b>11 mos.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>11 Oct 1959</b> to <b>12 Oct 1959</b> that I last saw the deceased alive on <b>12 Oct 1959</b> and that death occurred at <b>01:38 AM</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John W. Davis</b>		ADDRESS (Street, city or town, state) <b>U.S. NAVAL HOSPITAL, BETHESDA, MD</b>	
PHYSICIAN'S NAME (Type) <b>JOHN W. DAVIS, LT MC USN</b>		DATE SIGNED <b>10-12-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-15-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ozark Memorial</b>	22d. LOCATION (City, town, or county) (State) <b>Joplin, Missouri</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumphrey</b>		24a. REC'D BY REGISTRAR <b>OCT 13 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Chas. E. Howard</b>

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

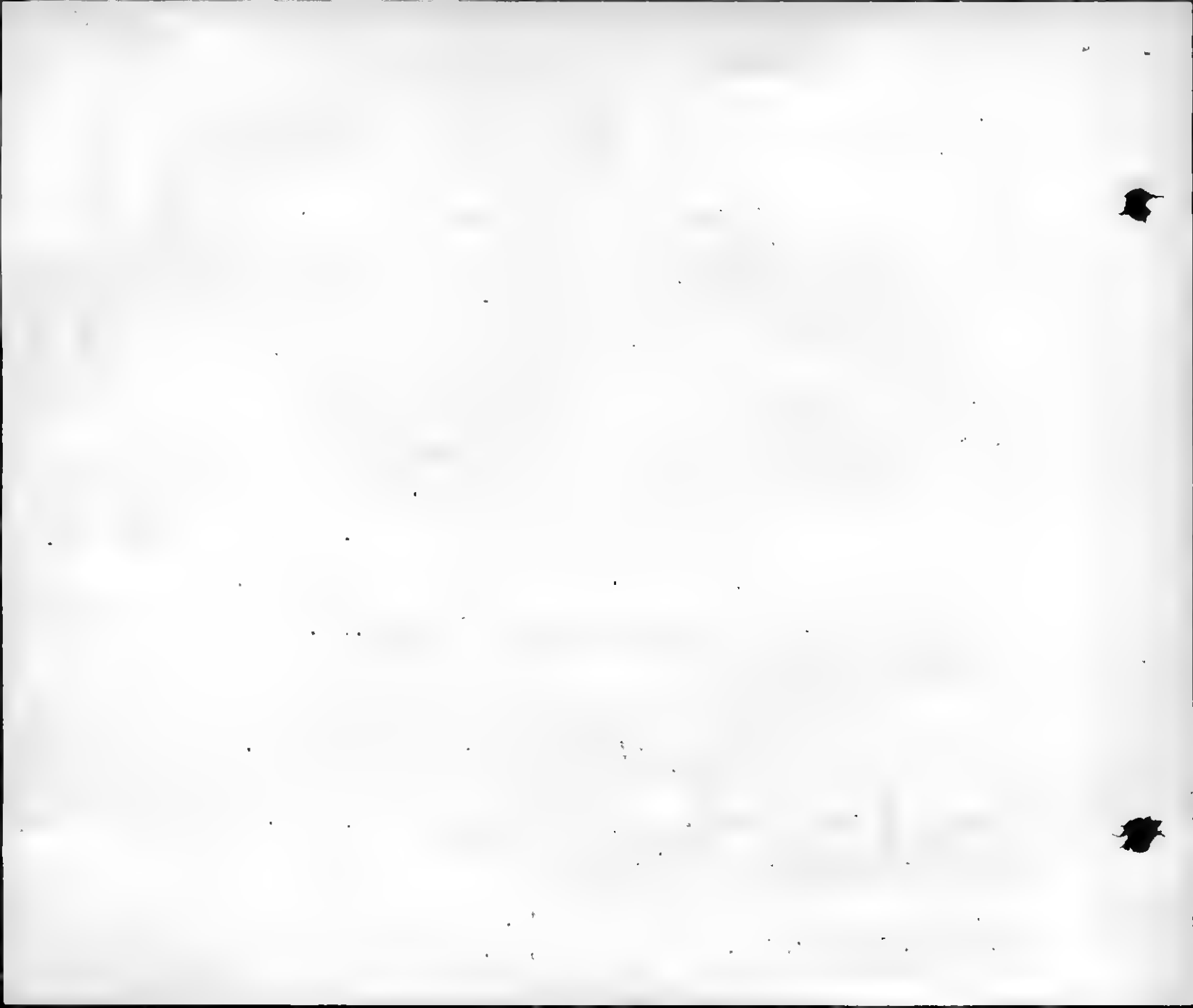
11521

## CERTIFICATE OF DEATH

Reg. Dist. No.

11615

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>MD</u> c. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give name of town) <u>Tafoma Park</u>				c. LENGTH OF STAY IN 1b <u>1 yr 11 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. San and Hosp.</u>				d. STREET ADDRESS <u>5708 40<sup>th</sup> Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Harley</u> First <u>Parker</u> Middle <u>-</u> Last <u>Parker</u>				4. DATE OF DEATH <u>Oct 7 1959</u> Month <u>Oct</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>fe</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-14-95</u> 94	
9. AGE (In years last birthday) <u>65</u> yrs		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>8</u> Hours <u>0</u> Min <u>0</u>		11. IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Army Nurse</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Army Nursing Corps</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Romulus Butt</u>				14. MOTHER'S MAIDEN NAME <u>Dorothy Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW #1</u>				16. SOCIAL SECURITY NO <u>none</u>			
17. INFORMANT <u>hospital Record</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause: (b) <u>Coronary Occlusion</u> (c) <u>Coronary Artery Sclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Primary Amyotrophic Lateral Sclerosis</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>Acute</u> <u>Acute</u>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. <u>19</u> Day. <u>7</u> Year. <u>1959</u> Hour a. m. <u>10</u> p. m. <u>00</u>				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>January 58</u> to <u>Oct. 7, 1959</u> , that I last saw the deceased alive on <u>Oct. 7, 1959</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James W. Wong</u>				ADDRESS (Street, city or town, state) <u>1025 Conn. Ave, D.C.</u> DATE SIGNED <u>10-8-59</u>			
PHYSICIAN'S NAME (Type) <u>James W. Wong</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>10/12/59</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>				22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR <u>OCT 13 '59</u> DATE			
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11616

11646

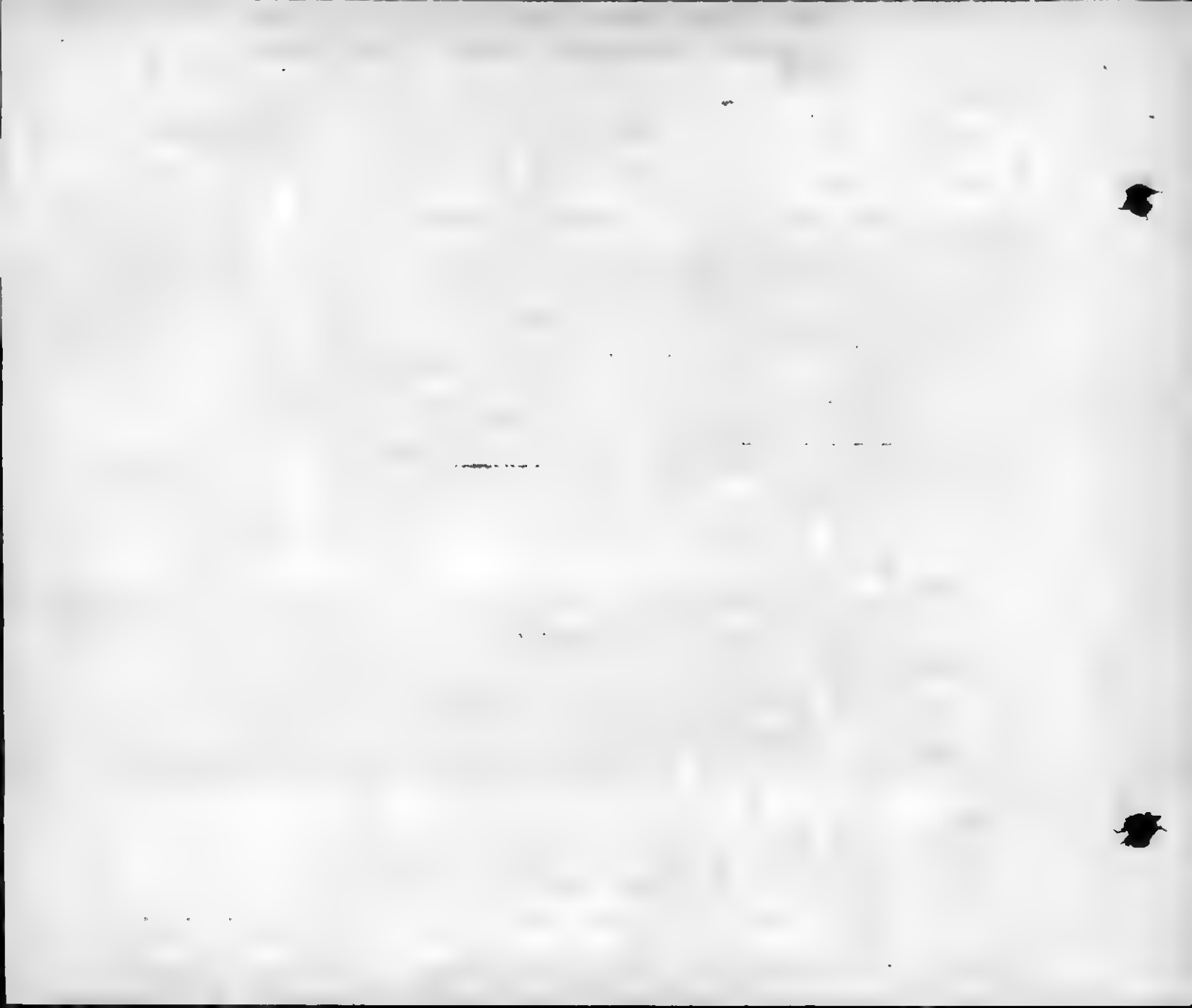
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland		b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Euclid Hosp		d. STREET ADDRESS 4446 Norwood Dr.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Douglas Llewellyn Parkhurst		4. DATE OF DEATH Month Day Year Oct. 12 1959			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/25/1393	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days 4 17
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov.		11. BIRTHPLACE (State or foreign country) New Hampshire	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Arthur W. Parkhurst		14. MOTHER'S MAIDEN NAME Beatrice Snyder	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Margaret Parkhurst (wife) Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) History of previous heart disease					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10/12/59	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-15-59	22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		22d. LOCATION (City, town, or county) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE OCT 14 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Fraws	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation or removal.



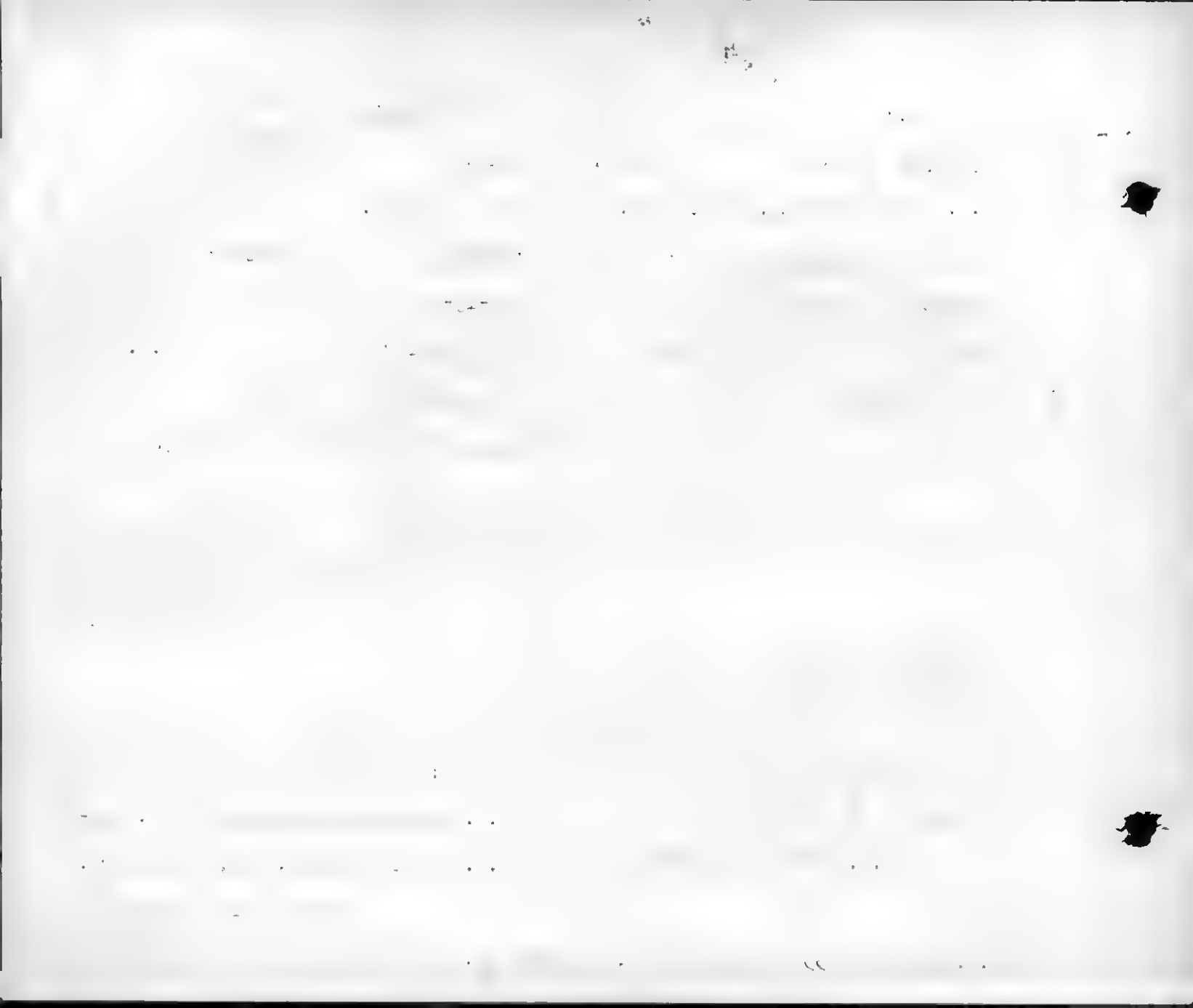
CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN lb <b>8 days</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>North Carolina</b> b. COUNTY <b>702</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Clinton</b>				d. STREET ADDRESS <b>308 Park Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <b>Eleanore Dianne PARSONS</b>				4. DATE OF DEATH Month <b>October</b> Day <b>28</b> Year <b>1959</b>				5. SEX <b>Female</b>				6. COLOR OR RACE <b>White</b>				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>11-13-49</b>				9. AGE (In years last birthday) <b>9</b>				10. IF UNDER 1 YEAR Months <b>1</b> Days <b>4</b> Hours <b>14</b> Min. <b>5</b>				11. IF UNDER 24 HRS Months <b>1</b> Days <b>4</b> Hours <b>14</b> Min. <b>5</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>				11. BIRTHPLACE (State or foreign country) <b>New York</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>				13. FATHER'S NAME <b>Loftin PARSONS</b>				14. MOTHER'S MAIDEN NAME <b>Ruth FORT</b>															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>				INFORMANT <b>(Father) Loftin Parsons</b>				Address <b>Same as #2</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>probably hemorrhage into bowel</b> 14.5 DUE TO <b>thrombocytopenia</b> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>acute lymphatic leukemia</b> DUE TO (c) <b>6 mo</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>1 mo.</b> <b>6 mo</b>															
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Hour <b>19</b> o. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>20 October</b> , 19 <b>59</b> , to <b>28 October</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>28 October</b> , 19 <b>59</b> , and that death occurred at <b>7:12 P</b> M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda Md.</b>				DATE SIGNED <b>10-29-59</b>				ACTUAL SIGNATURE <b>G.B. Avery</b>				PHYSICIAN'S NAME (Type) <b>G.B. AVERY LT MC USN</b>				U.S. Naval Hospital, NNMC, Bethesda, Md.															
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>11-1-59</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Clinton</b>				22d. LOCATION (City, town, or county) <b>Clinton North Carolina</b>				23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumphrey</b>				ADDRESS <b>7357 Wisconsin Ave. Bethesda Md.</b>				24a. REC'D BY REGISTRAR <b>NOV 2 '59</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11648

## CERTIFICATE OF DEATH

11618

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b> c. LENGTH OF STAY IN 1b <b>10 DAYS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) <b>MONTGOMERY COUNTY GENERAL HOSPITAL</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HOWARD</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELLICOTT CITY</b> d. STREET ADDRESS <b>HORSE SHOE ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WESLEY</b> Middle <b>CLARENCE</b> Last <b>PEUGH</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>7</b> Year <b>19 59</b>					
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/10/15</b>	9. AGE (In years last birthday) <b>43</b> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>JANITOR</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>JANITOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BOARD OF EDUCATION</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>URIAH WASHINGTON PEUGH</b>			14. MOTHER'S MAIDEN NAME <b>LUCY WARFIELD</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>HOSPITAL RECORDS</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Peritonitis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Ruptured diverticulitis of sigmoid colon</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b> <b>3 weeks</b>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>9/27, 1959</b> to <b>10/7, 1959</b> that I last saw the deceased alive on <b>10/7, 1959</b> , and that death occurred at <b>2:55A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Charles S. Whitaker, M.D.</b>							
PHYSICIAN'S NAME (Type) <b>CHARLES S. WHITAKER, M. D.</b>		<b>CLARKSVILLE, MARYLAND</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-10-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Meadowside Memorial</b>	22d. LOCATION (City, town, or county) <b>Dorsey, Md</b>	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md</b>		24a. REC'D BY REGISTRAR <b>OCT 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. King</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11619

Reg. Dist. No.

11645

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>10 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2421 Eccleston st</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>5 Silver Spring</u> d. STREET ADDRESS <u>2421 Eccleston st</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Mary Lynne Rickell</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>10-27-1959</u>							
<b>5. SEX</b> <u>female</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>6-1-1911</u>		<b>9. AGE</b> (In years last birthday) <u>48</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>N. J.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.C.</u>			
<b>13. FATHER'S NAME</b> <u>Whitney Lyman</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Josephine Vollmer</u>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>none</u>		<b>17. INFORMANT</b> Address <u>Clarence Rickell - Ill-2</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>Coronary occlusion</u> <u>12/01</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>DUE TO (c)</b> (a), stating the underlying cause last.								<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>sudden</u>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>	
<b>21. I certify that I took charge of the remains described above, held on Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>											
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broseholt</u> M.D. <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>EXAMINER'S NAME (Type)</b> <u>FRANK J. BROSEHOLT</u> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <u>Raymond A. Ziska</u> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>						<b>DATE SIGNED</b> <u>10-27-59</u>					
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>				<b>22b. DATE THEREOF</b> <u>10/30/59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>ST. JOHN'S CEMETERY</b>				<b>22d. LOCATION (City, town, or county)</b> <b>(State)</b> <b>MONTGOMERY COUNTY, MARYLAND</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Raymond A. Ziska</u>						<b>ADDRESS</b> <b>SILVER SPRING, MD.</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <u>OCT 29 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



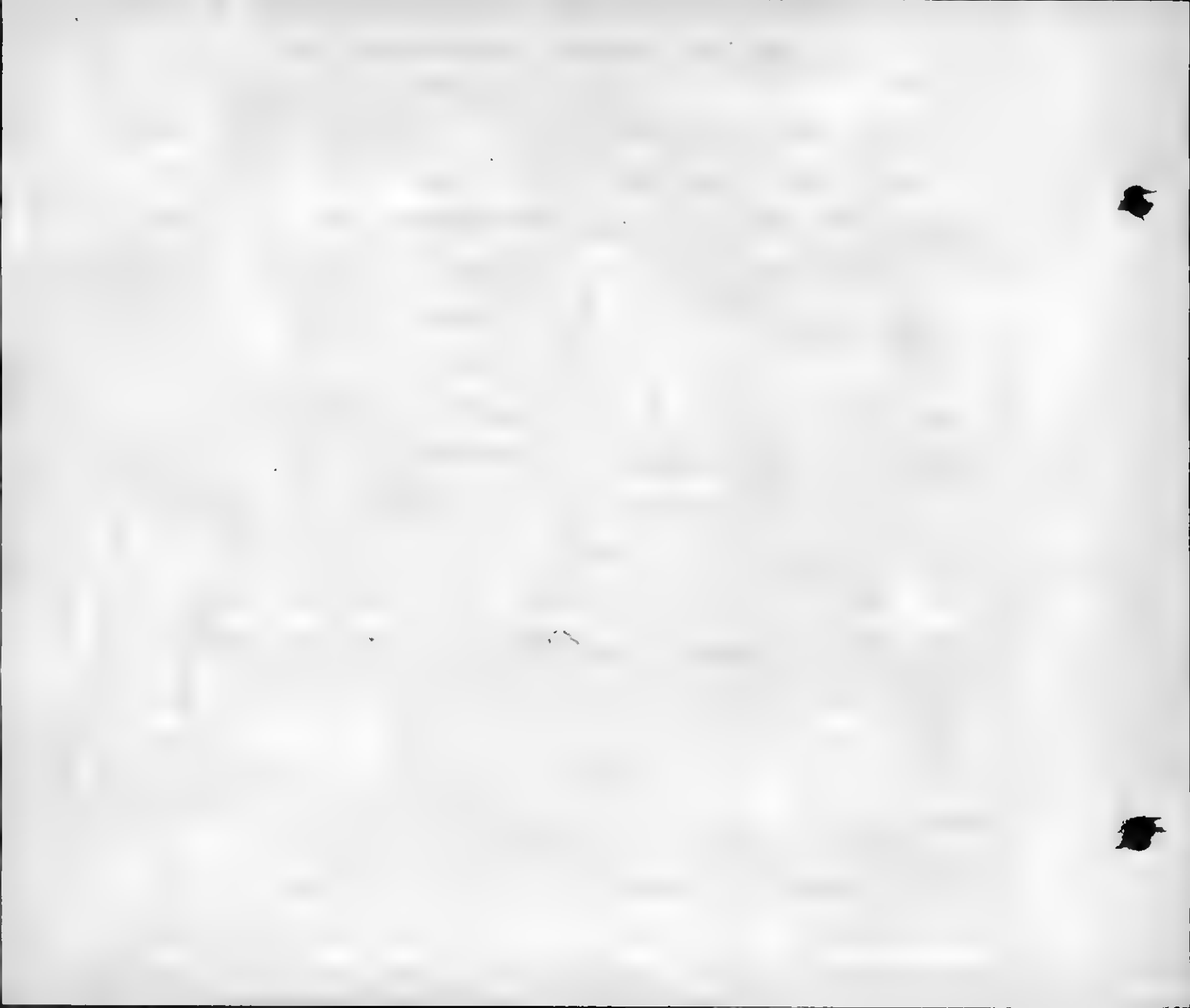
11522

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>40 minutes</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium</u>				d. STREET ADDRESS <u>6708 Prince Georges Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Gilbert</u> Middle <u>Lee</u> Last <u>Porter, Jr</u>				4. DATE OF DEATH Month <u>10</u> Day <u>12</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-9-03</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bus Driver (Ret.)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. Transit</u>		11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Leonard L. Porter</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Atherton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Mrs Kathryn Porter (wife)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MASSIVE RETROPERITONEAL HEMORRHAGE</u> <u>451X</u> DUE TO <u>ABDOMINAL</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>RUPTURED ARTERIOSCLEROTIC ANEURYSM OF AORTA</u> DUE TO <u>2 DAYS</u> (c) <u>2 DAYS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SEVERE CORONARY ARTERIOSCLEROSIS WITH SEVERAL FOCI OF COMPLETE OCCLUSION</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschelt</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHELT</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>10-12-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/13/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wallace Funeral Home</u>				ADDRESS <u>3200 N. P. Ave. Mt. Airy, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE OCT 14 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Carroll E. K...</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

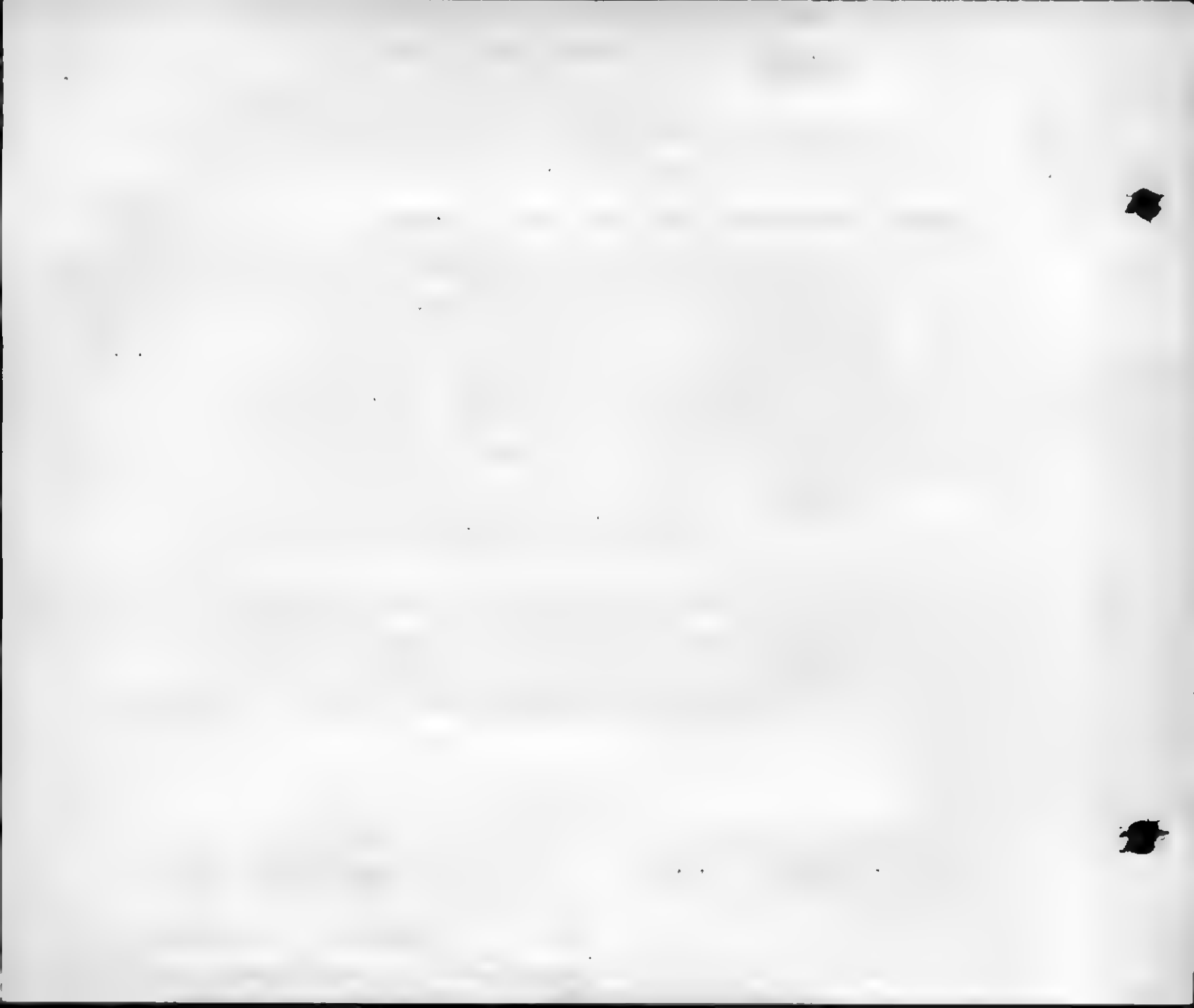
11621

11650

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>8 hrs. 28min</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital, Inc.</b>		d. STREET ADDRESS <b>Rt. #1</b>	
3. NAME OF DECEASED (Type or print) <b>Charles Anthony Prather</b>		4. DATE OF DEATH <b>October 4, 1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 4, 1959</b>
9. AGE (In years last birthday) <b>NB yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min <b>8 28</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NB</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Theodore John Jackson</b>		14. MOTHER'S MAIDEN NAME <b>Janet Elizabeth Prather</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia neonatorum</b> 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Fetal distress in utero</b> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <b>8 1/2 hours</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. / 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10-4</b> 19 <b>59</b> , to <b>10-4</b> 19 <b>59</b> , that I last saw the deceased alive on <b>10-4</b> 19 <b>59</b> , and that death occurred at <b>9 1/2</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Jack Schumacher</b> M.D.		ADDRESS (Street, city or town, state) <b>Gaithersburg, Maryland</b>	
DATE SIGNED <b>10-5-59</b>			
PHYSICIAN'S NAME (Type) <b>J. Schumacher, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-7-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Park</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert R. Sander</b> ADDRESS <b>Rockville, Md</b>		24a. REC'D BY REGISTRAR <b>Oct 8 59</b> DATE	
24b. REGISTRAR'S SIGNATURE <b>Arthur A. Rouse</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11651

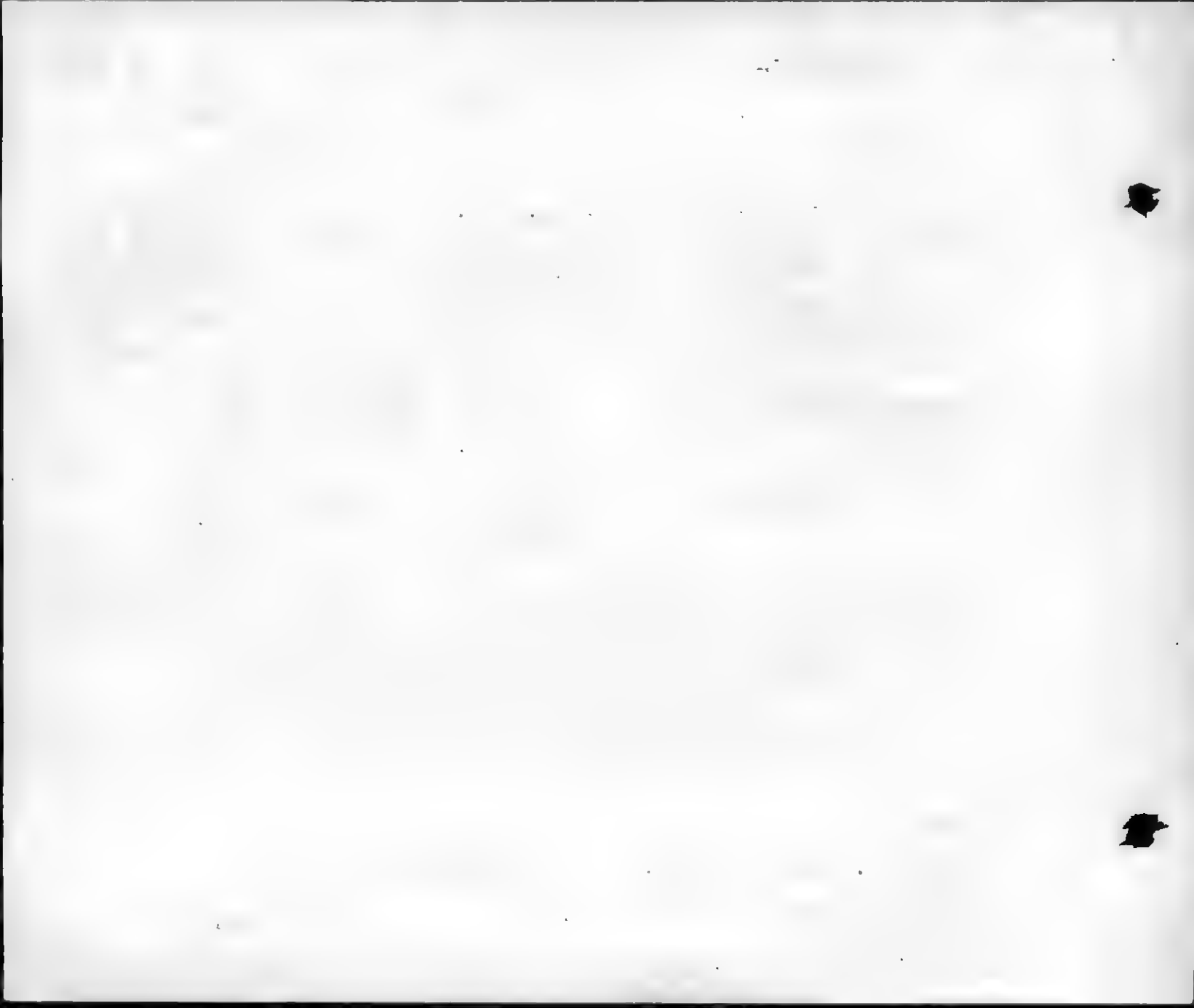
## CERTIFICATE OF DEATH

Reg. Dist. No. 11622

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		c. LENGTH OF STAY IN 1b <b>12 DAYS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GAITHERSBURG</b>		d. STREET ADDRESS <b>Rt. #2 Box 70</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY COUNTY GENERAL HOSPITAL, INC.</b>		3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>JAMES</b> Last <b>PRATHER</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>12</b> Year <b>1959</b>		5. SEX <b>MALE</b>		6. COLOR OR RACE <b>NEGRO</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/1/59</b>	
9. AGE (In years last birthday) <b>12</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>EDWARD JAMES OFFUTT</b>		14. MOTHER'S MAIDEN NAME <b>MAUDE LANCASTER PRATHER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT <b>HOSPITAL RECORDS</b>		Address <b>OLNEY, MD.</b>		17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Bronchopneumonia</b> <b>123.5</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Prematurity and Immaturity</b> (c) <b>DUE TO</b>		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>OCTOBER 1, 1959</b> , to <b>OCTOBER 12, 1959</b> , that I last saw the deceased alive on <b>Oct. 12, 1959</b> , and that death occurred at <b>8:25 A.M.</b> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <b>Jack Schumacher</b>		M.D.		ADDRESS (Street, city or town, state) <b>10-13-59</b>		DATE SIGNED		PHYSICIAN'S NAME (Type) <b>J. SCHUMACHER, M. D.</b>		GAITHERSBURG, MARYLAND		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
22b. DATE THEREOF <b>10/13/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Brooks Grove</b>		22d. LOCATION (City, town, or county) <b>Laytonsville, Md</b>		22e. (State) <b>Md</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert C. Schumacher</b>		ADDRESS <b>Rockville, Md</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 15 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>		24c. (City or town)		24d. (County)		24e. (State)		24f. (City or town)		24g. (County)		24h. (State)	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11623

11652

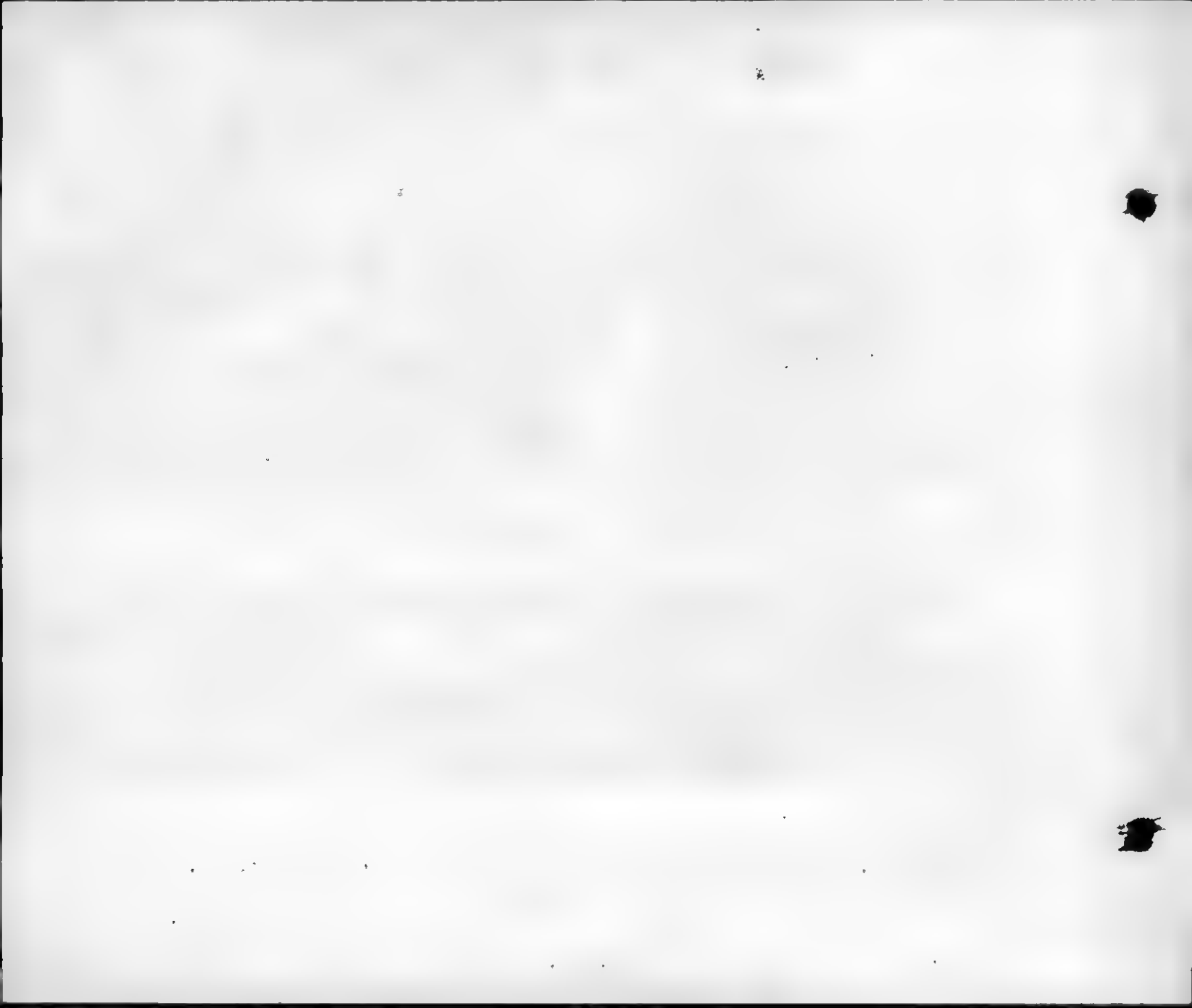
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington - D.C.</u>	
c. LENGTH OF STAY IN 1b <u>6 mo.</u>		d. STREET ADDRESS <u>2321 Lincoln Rd. N.E.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Trances M. Price</u>		4. DATE OF DEATH <u>Oct. 1 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 9, 1888</u>
9. AGE (In years last birthday) <u>71</u> yrs		10. IF UNDER 1 YEAR: Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Brooklyn - NY</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Unk.</u>		14. MOTHER'S MAIDEN NAME <u>Unk.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Husband</u>		18. ADDRESS <u>2321 Lincoln Rd. - N.E. R. Price apt. 108 Wash. D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes Hypertension</u> DUE TO <u>Arterio Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Sept Haemophilic</u> DUE TO (c) <u>6 mm</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mm</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-7-1959</u> to <u>10-1-1959</u> , that I last saw the deceased alive on <u>9/1/59</u> , <u>1959</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. H. Bird</u>		ADDRESS (Street, city or town, state) <u>Sandy Springs, Md.</u>	
PHYSICIAN'S NAME (Type) <u>J. H. Bird</u>		DATE SIGNED <u>10/1/59</u>	
22a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/3/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Port Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE OCT 5 1959</u>		24b. REGISTRAR'S SIGNATURE <u>John R. H. H.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, who shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



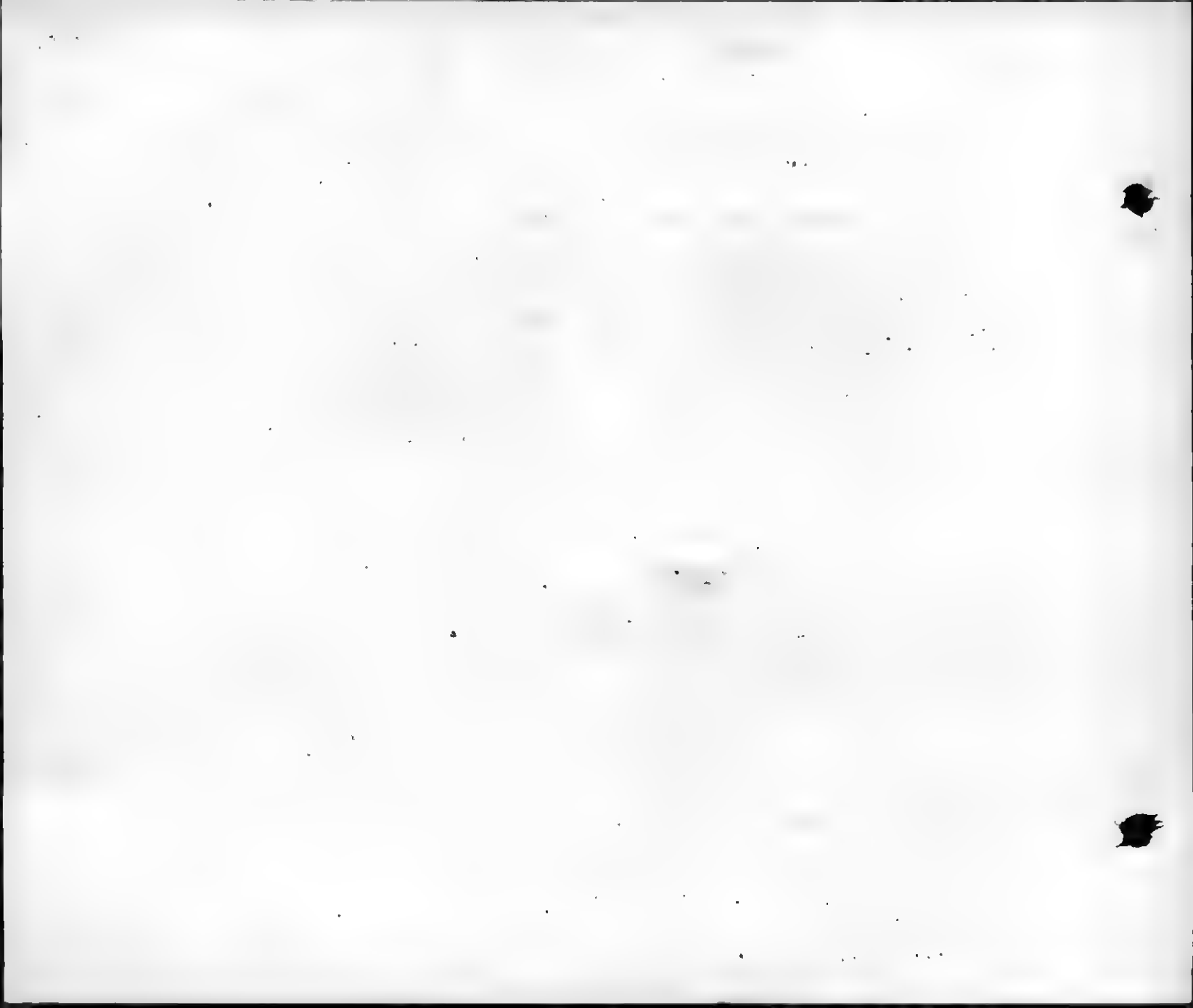
11523

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If not put on Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hosp</u>		d. STREET ADDRESS <u>1125 Spring Rd NW</u>	
3. NAME OF DECEASED (Type or print) First <u>Pearl</u> Middle <u>Raine</u> Last <u>Raine</u>		4. DATE OF DEATH Month <u>10</u> Day <u>30</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Jew</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-15-84</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u>76</u> Days <u>76</u> Hours <u>76</u> Min <u>76</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Refuse house duties</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Russia</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>165-128637A</u>	
17. INFORMANT <u>Zelda Widom</u>		Address <u>5816 44th St NW</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Extensive Coronary Arteriosclerosis</u> DUE TO (b) <u>Myocardial Infarction</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>years</u> <u>recent</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>generalized Arteriosclerotic Endarteritis, Recent Head Artery Embolism</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/4</u> , 19 <u>59</u> , to <u>10/30</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10/30</u> , 19 <u>59</u> , and that death occurred at <u>2:50 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Maxim L. Delkin</u>		ADDRESS (Street, city or town, state) <u>8485 Fenton Street, S.S., Md.</u>	
PHYSICIAN'S NAME (Type) <u>1</u>		DATE SIGNED <u>Nov 3 '59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-1-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Calverton</u>		22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Golding Funeral Home</u>		24a. REC'D BY REGISTRAR <u>Nov 3 '59</u>	
ADDRESS <u>4217 9th Ave NW</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11538

### CERTIFICATE OF DEATH

11625

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCKVILLE 22303</b> c. LENGTH OF STAY IN 1b <b>1 MONTH</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>13303 KEATING DRIVE</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>17 TAKOMA PARK</b> d. STREET ADDRESS <b>6606 WESTMORELAND AVE.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>AMASA STEWART RANDALL</b>				4. DATE OF DEATH Month Day Year <b>OCTOBER 22 19 59</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/28/71</b>	
9. AGE (In years last birthday) <b>87</b>		10. AGE UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Virginia Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Proprietor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Book Printing Office</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia Tennessee</b>	
13. FATHER'S NAME <b>James Jefferson Randall</b>				14. MOTHER'S MAIDEN NAME <b>Elean Thomas</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>		INFORMANT <b>HOSPITAL RECORDS</b>		Address <b>OLNEY, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>600.0</b> DUE TO <b>Pyelonephritis, Chronic</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pyelonephritis, Chronic</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>1 mo.</b> <b> yrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Compression fracture 1st Lumbar Vertebra.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/22 1959</b> to <b>10/22 1959</b> , that I last saw the deceased alive on <b>10/15 1959</b> , and that death occurred at <b>3:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>10/22/59</b>							
ACTUAL SIGNATURE <b>C. H. LIGON, M. D.</b>				M.D. <b>SANDY SPRING, MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 24, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Prince George's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Prince George's County Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Arthur Walters, 254 Carroll St. N.W. D.C.</b>				24. REC'D BY REGISTRAR <b>OCT 26 '59</b>		24. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	



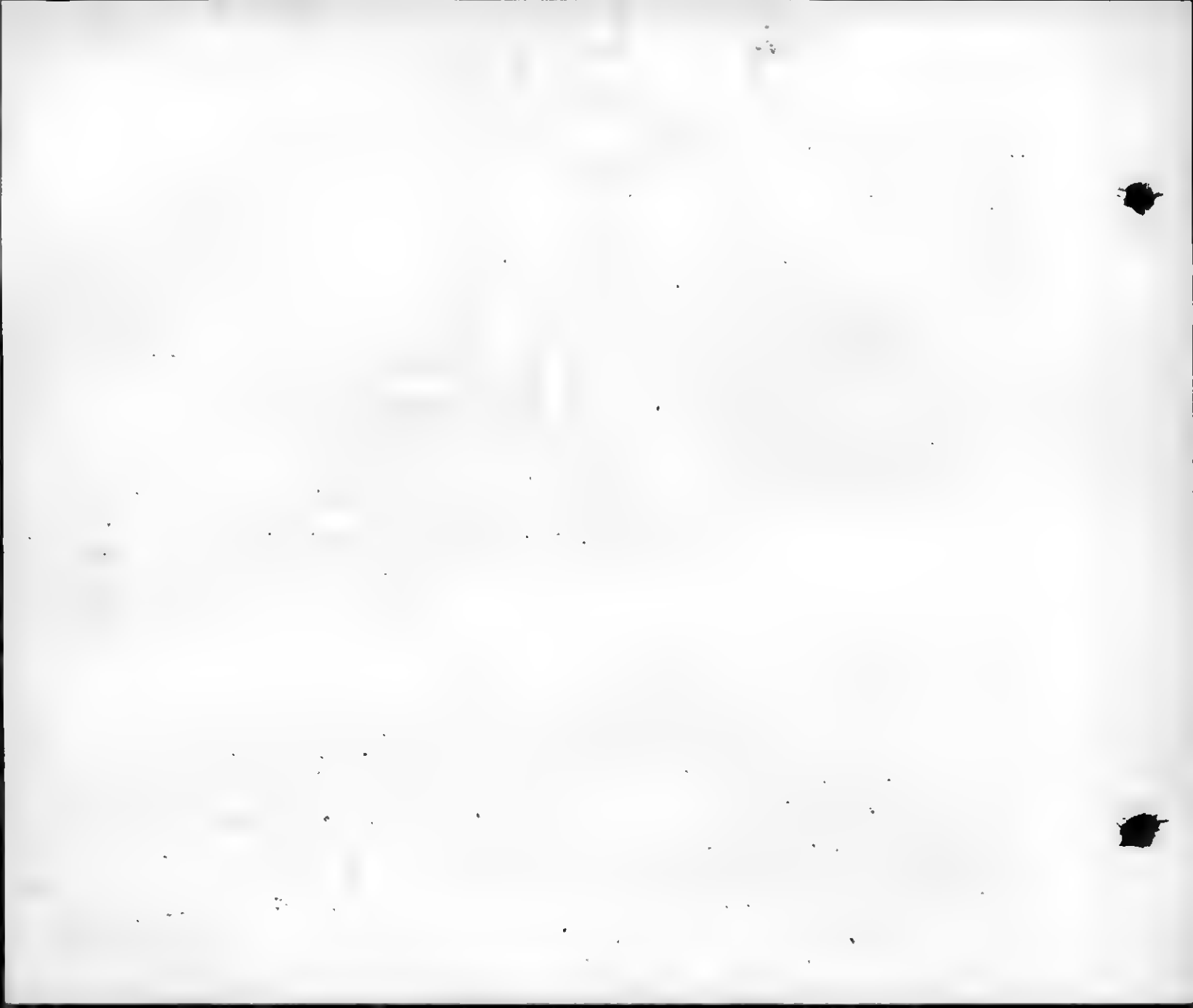
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**11524** **CERTIFICATE OF DEATH**

11626

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>          </u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Iskoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Korristown</u>			
c. LENGTH OF STAY IN 1b <u>16 days</u>				d. STREET ADDRESS <u>14 E Woodlyn Ave.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium &amp; Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Kathryn Anna Rauch</u>		4. DATE OF DEATH Month <u>10</u> Day <u>19</u> Year <u>1959</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-3-09</u>		9. AGE (In years last birthday) <u>50</u> yrs		IF UNDER 1 YEAR: Months <u>          </u> Days <u>          </u> Hours <u>          </u> Min <u>          </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>          </u>		11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William H. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Mary Hill</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>          </u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized metastasis</u> DUE TO (b) <u>Hemangiosarcoma</u> gave rise to immediate cause (a), stating the underlying cause last. (c) <u>of left groin</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>7 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>          </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>          </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>          </u> p. m. <u>          </u> 19 <u>59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>          </u>		20f. (City or town) <u>          </u> (County) <u>          </u> (State) <u>          </u>	
21. I certify that I attended the deceased from <u>Oct 2</u> , 19 <u>59</u> , to <u>Oct 19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct 18</u> , 19 <u>59</u> , and that death occurred at <u>4:45 a.m.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. W. Eastman</u>				ADDRESS (Street, city or town, state) <u>8700 Coleville Road Silver Spring Md</u>			
PHYSICIAN'S NAME (Type) <u>W. W. Eastman</u>				DATE SIGNED <u>          </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>          </u>		22b. DATE THEREOF <u>OCT 22 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>VALLEY FORGE GARDENS</u>		22d. LOCATION (City, town, or county) (State) <u>KING OF PRUSSIA MONTG. PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>          </u>				24a. REC'D BY REGISTRAR <u>          </u>		24b. REGISTRAR'S SIGNATURE <u>          </u>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





11653

## CERTIFICATE OF DEATH

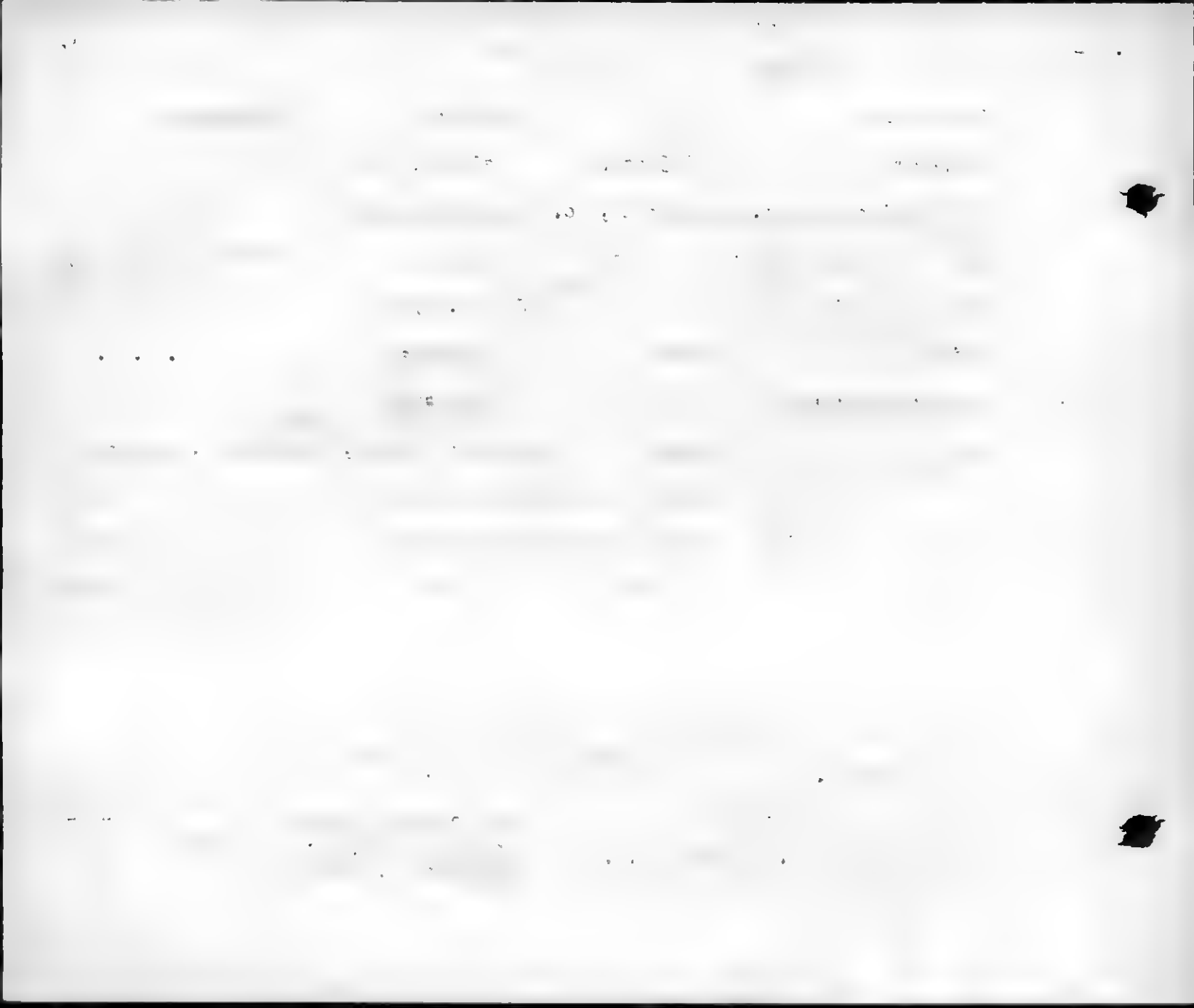
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>153 days</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>		d. STREET ADDRESS <b>117 Lee Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Kenneth Ray Reedy</b>		4. DATE OF DEATH Month Day Year <b>October 30 1959</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 1, 1951</b>		9. AGE (In years last birthday) <b>8 yrs</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Gilmer Ray Reedy</b>		14. MOTHER'S MAIDEN NAME <b>June Vanhoy</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>The Medical Record</b>		18. ADDRESS <b>The Clinical Center, Bethesda 14, Maryland</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Massive retroperitoneal hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>MISS and Hemorrhagic bronchopneumonia</b> DUE TO (b) <b>Acute lymphocytic leukemia</b> (c) <b>9 months</b>		INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>3 days</b> <b>9 months</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>May 30</b> , 19 <b>59</b> , to <b>October 30</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>October 30</b> , 19 <b>59</b> , and that death occurred at <b>9:35 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>10-30-59</b> ACTUAL SIGNATURE <b>Richard C. Mechanic</b> PHYSICIAN'S NAME (Type) <b>Richard C. Mechanic, M.D.</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/3/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Independence, Va.</b>		22d. LOCATION (City, town, or county) (State)		24a. REC'D BY REGISTRAR DATE <b>NOV 3 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>W W Chambers Co</b>		ADDRESS <b>1400 Chapin St NW Wash, D.C.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 3 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>							

1

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
TSM 9/58



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

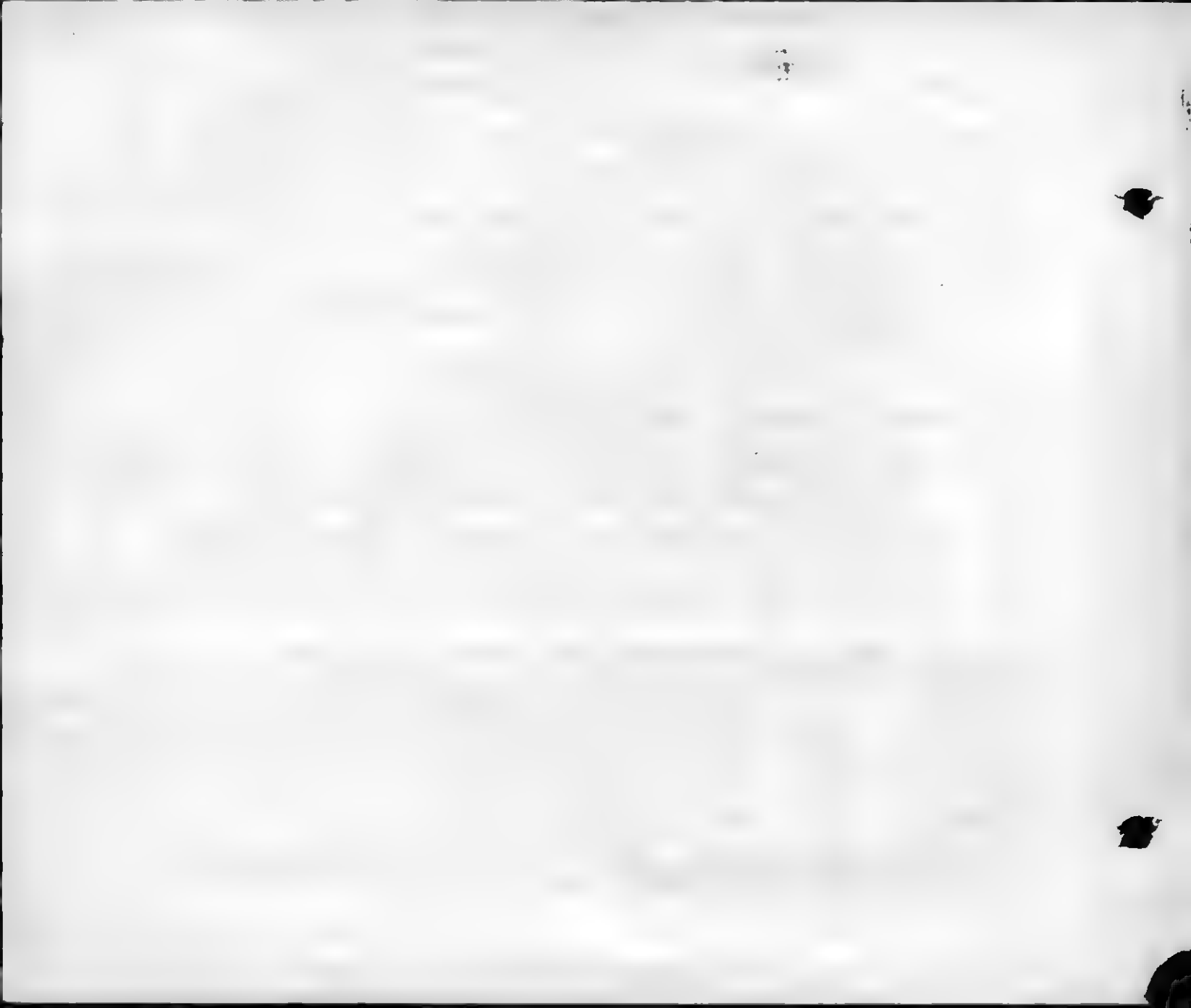
11628

11654

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9500 FOREST RD.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Sophia B. Reichgott</b>				4. DATE OF DEATH <b>Oct. 23 1959</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>APRIL 10, 1891</b>	
9. AGE (In years lost birthday) <b>68</b> yrs.		IF UNDER 1 YEAR: Months Days		IF UNDER 24 HRS: Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>NEW HAVEN CONN.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>PHILIP BERNSTEIN</b>				14. MOTHER'S MAIDEN NAME <b>ELIZABETH LUBIN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>LUCILLE GUTTERMAN</b> Address <b>9500 FOREST RD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intestinal Obstruction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Adenocarcinoma, Ovarian, Metastatic</b> DUE TO (c) <b>ly.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Anemia</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 10, 1958</b> to <b>Oct 23 1959</b> , that I last saw the deceased alive on <b>Oct 23 1959</b> , and that death occurred at <b>11:20 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>George B. Patrick Jr.</b> M.D.				ADDRESS (Street, city or town, state) <b>9221 Colesville Rd</b> DATE SIGNED <b>10/29/59</b>			
PHYSICIAN'S NAME (Type) <b>George B. Patrick, Jr. M.D.</b>				Silver Spring, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>OCT. 27, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <b>NEW HAVEN CONN</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>BERNARD DANZANSKY &amp; SONS</b> ADDRESS <b>WASH. DC 3501-14 ST NW</b>				24a. REC'D BY REGISTRAR DATE <b>OCT 28 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kinnear</b>	



## CERTIFICATE OF DEATH

Reg Dist No

11629

11655

1 PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>22 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>		2 USUAL RESIDENCE (Where deceased lived If institution Res dence before admission) a. STATE <b>(District of Columbia)</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>5158 H St., S.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Camille Teresa RENFRO</b>		4 DATE OF DEATH Month Day Year <b>October 20 1959</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>Negro</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>9-25-59</b>
9 AGE (In years last birthday) <b>15</b>		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	10b KIND OF BUSINESS OR INDUSTRY <b>None</b>
11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13 FATHER'S NAME <b>Bobby Joe RENFRO</b>		14 MOTHER'S MAIDEN NAME <b>Thomasine E. Foreman</b>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>None</b>	
17 INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> 100.00 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>PREMATURITY</b> DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I attended the deceased from <b>29 September 1959</b> to <b>20 October 1959</b> , that I last saw the deceased alive on <b>20 October 1959</b> , and that death occurred at <b>9:00 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Fred W. Grello</b> M.D. <b>U. S. Naval Hospital, Bethesda Md.</b> <b>10-21-59</b>			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <b>F. W. GRELLIO LT MC USN</b> <b>U. S. Naval Hospital, Bethesda, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-23-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Alexander Pope</b> <b>ALEXANDER POPE FUNERAL HOME, 415 15th St., S.E. Washington, D.C.</b>		24a. REC'D BY REGISTRAR'S <b>Oct 23 1959</b> 24b. REGISTRAR'S SIGNATURE <b>Robert S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be relayed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11630

Reg. Dist. No.

11656

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		c. LENGTH OF STAY IN 1b <u>6 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8706 Preston Place</u>				d. STREET ADDRESS <u>8706 Preston Place</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jean</u> Middle <u>Goldfather</u> Last <u>Richardson</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>26</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-26-13</u>	
9. AGE (In years last birthday) <u>46</u> yrs.		10. UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Ernest Goldfather</u>				14. MOTHER'S MAIDEN NAME <u>Katherine McIntire</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>WM 4. Richardson - Sister 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>10-26-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		22b. DATE THEREOF <u>10-26-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ewing Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Preston, New Jersey</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>OCT 30 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Conrad S. Hines</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.





## CERTIFICATE OF DEATH

Reg. Dist. No.

11657

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>				c. LENGTH OF STAY IN 1b <b>6 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY COUNTY GENERAL HOSPITAL, INC.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>ADRIAN</b> Last <b>RIDGELY</b> <b>RXXXXX</b>				4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>19</b> Year <b>19 59</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>2/12/87</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER - Farmer</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>WILLIAM ADRAIN RIDGELY</b>				14. MOTHER'S MAIDEN NAME <b>MARIE ANTOINETTE OFFUTT</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]				16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>HOSPITAL RECORDS</b>			
17. ADDRESS <b>OLNEY, MD.</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ruptured Aortic Aneurysm</b> <b>451X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(left Common Iliac)</b> DUE TO <b>Arteriosclerosis</b> (c) <b>Arteriosclerosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>10-13</b> , 19 <b>59</b> , to <b>10-19</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>10-14</b> , 19 <b>59</b> , and that death occurred at <b>9:52 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>J. Schumacher</b> M.D.				ADDRESS (Street, city or town, state) <b>GAITHERSBURG, MARYLAND</b>			
PHYSICIAN'S NAME (Type) <b>J. SCHUMACHER, M. D.</b>				DATE SIGNED <b>Oct 10. 20 59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-23-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove</b>		22d. LOCATION (City, town, or county) (State) <b>Stearns, Howard Co. MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur H. Haight</b>				ADDRESS <b>Hydenville, Md.</b>		24a. REC'D BY REGISTRAR <b>OCT 26 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles E. Frank</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11658

## CERTIFICATE OF DEATH

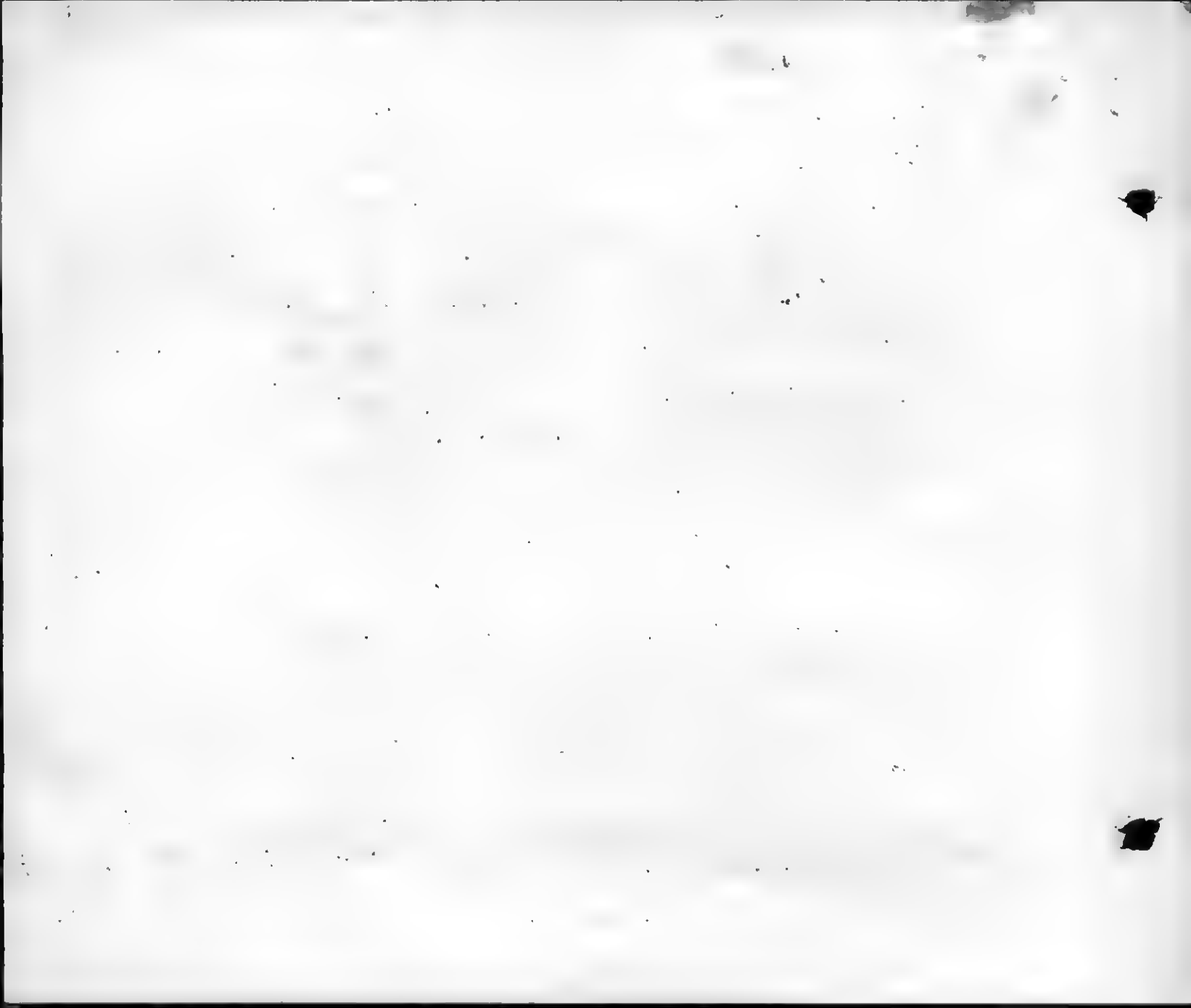
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY,</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA,</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5419 Glenwood Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>TORBERT</b> Last <b>RILEY</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>29,</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 22, 1901</b>
9. AGE (In years last birthday) <b>58</b>		10. IF UNDER 1 YEAR Months <b>58</b> Days <b>58</b> Hours <b>58</b> Min. <b>58</b>	11. IF UNDER 24 HRS Months <b>58</b> Days <b>58</b> Hours <b>58</b> Min. <b>58</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Berwyn, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Francis Peyton Torbert</b>		14. MOTHER'S MAIDEN NAME <b>Anna Dalrymple</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Husband</b>		Address <b>Same as Item #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1 COLONARY OCCLUSION</b> DUE TO (b) <b>COLONARY THROMBOSIS</b> DUE TO (c) <b>COLONARY ARTERY SCLEROSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>ACUTE</b> <b>ACUTE</b> <b>15+ YRS.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PRIMARY ARTERIAL HYPERTENSION</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>o. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1950</b> , 19____, to <b>OCT. 29, 1959</b> , that I last saw the deceased alive on <b>OCT. 16,</b> 19 <b>59</b> , and that death occurred at <b>11:45</b> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1025 CONN. AVE. N.W. WASH. DC.</b> DATE SIGNED <b>OCTOBER 29, 1959.</b>			
ACTUAL SIGNATURE <b>James W. Long</b> M.D.		DATE SIGNED <b>OCTOBER 29, 1959.</b>	
PHYSICIAN'S NAME (Type) <b>James W. Long</b>		ADDRESS <b>1025 CONN. AVE. N.W. WASH. DC.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-31-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>	22d. LOCATION (City, town, or county) (State) <b>Prince George County, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY,</b> ADDRESS <b>Bethesda, Md.</b>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <b>Clara S. Kane</b>

VS A15 (4)  
15M 9/58

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NOV 2



11659

## CERTIFICATE OF DEATH

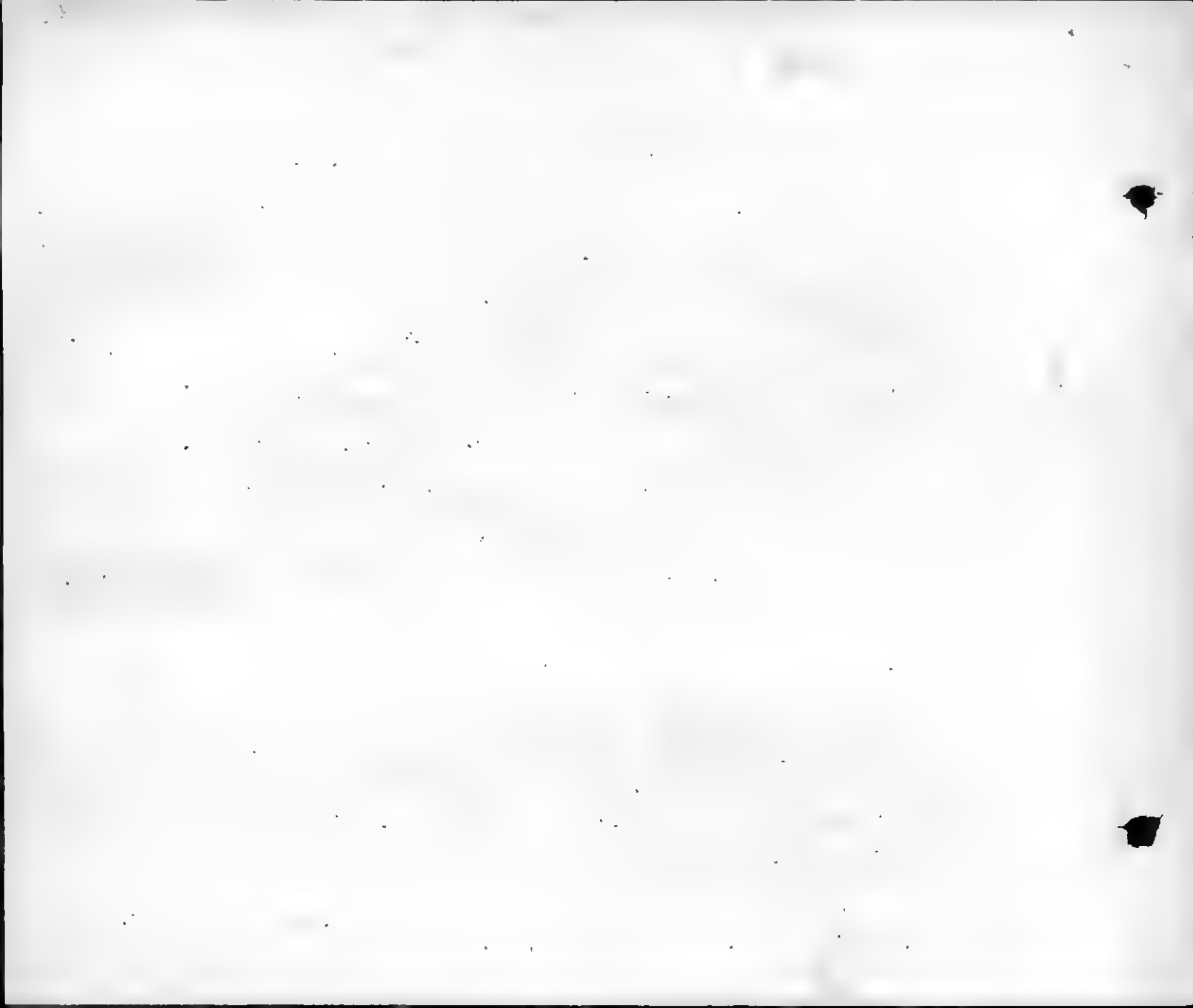
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. LENGTH OF STAY IN 1b <u>2 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JEAN</u> Middle <u>T.</u> Last <u>RITCHIE</u>				4. DATE OF DEATH Month <u>10</u> Day <u>31</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-31-1900</u>	
9. AGE (In years last birthday) <u>58</u> yrs		IF UNDER 1 YEAR Months <u>58</u> Days <u>58</u> Hours <u>58</u> Min. <u>58</u>		IF UNDER 24 HRS. Months <u>58</u> Days <u>58</u> Hours <u>58</u> Min. <u>58</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>TANKERSLEY UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>226-14-2733</u>			
17. INFORMANT <u>Mrs. Jane (Daughter) Same as above</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>497.1</u> DUE TO <u>Posterior Myocardial Infarction</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Occlusion</u> <u>3 days</u> (c) <u>Coronary Artery Sclerosis</u> <u>10 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> 19 <u>19</u> p.m.				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Fall, 1957, to 21 Oct, 1959</u> , that I last saw the deceased alive on <u>20 Oct, 1959</u> , and that death occurred at <u>12:50 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>11134 Georgia Ave Silver Spring, Md.</u> DATE SIGNED <u>21 Oct 59</u>							
ACTUAL SIGNATURE <u>Merton L. White</u> M.D.							
PHYSICIAN'S NAME (Type) <u>MERTON L. WHITE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/23/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY INC. Raymond A. Ziska</u>				24a. REC'D BY REGISTRAR <u>OCT 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Robert S. Evans</u>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11660

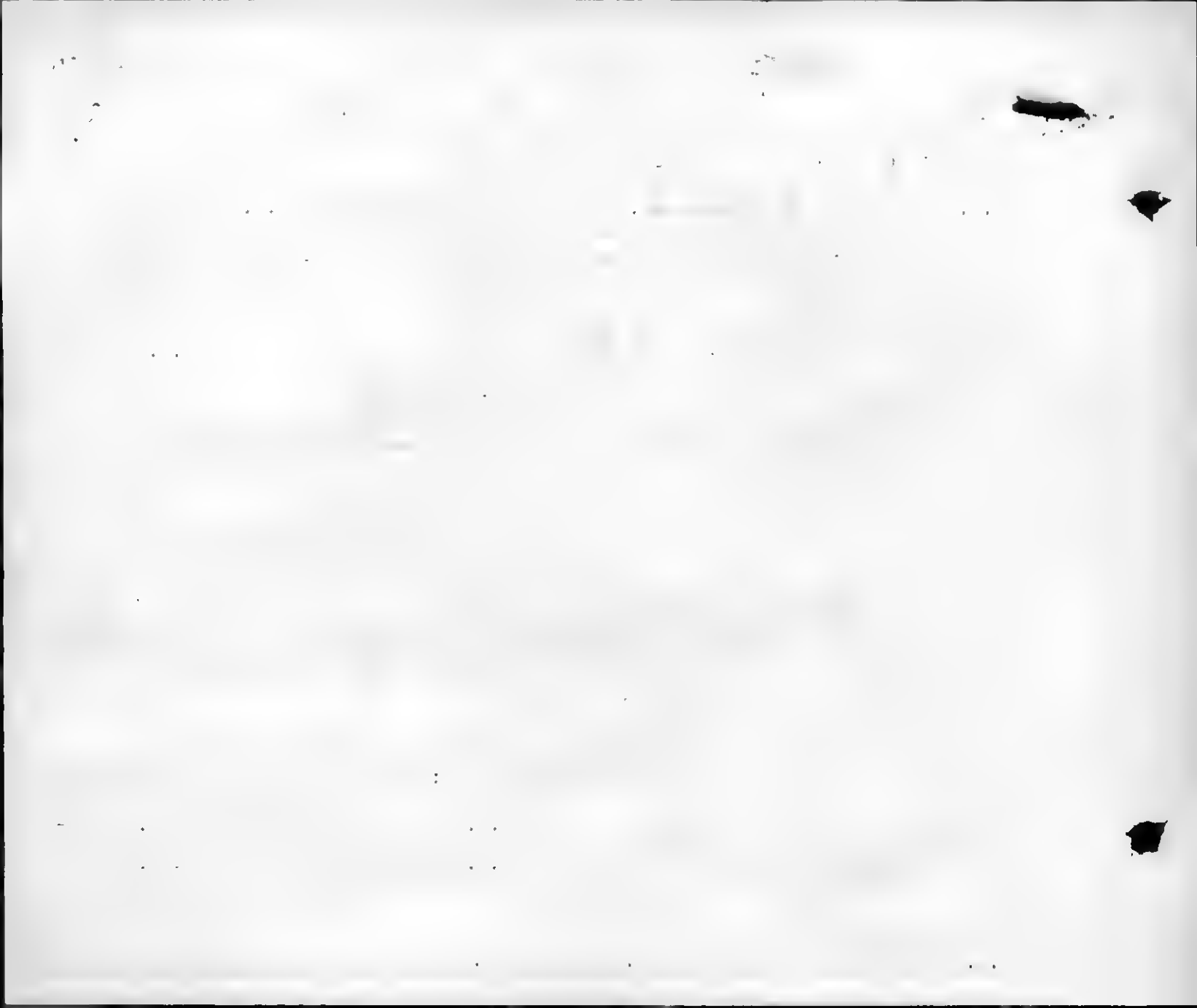
## CERTIFICATE OF DEATH

Reg. Dist. No. 215

11634

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>180 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town), <b>Washington</b> d. STREET ADDRESS <b>3706 VanNess Street N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>John William ROSSON</b>		4. DATE OF DEATH Month Day Year <b>October 28 19 59</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-11-88</b>
9 AGE (In years last birthday) <b>71</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>71</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>	
11. BIRTHPLACE (State or foreign country) <b>Vermont Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John ROSSON</b>		14. MOTHER'S MAIDEN NAME <b>Louise BROADDUS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes 1918 to 1919</b>		16. SOCIAL SECURITY NO <b>none</b>	
17. INFORMANT <b>(wife) Annie Mae ROSSON</b>		Address <b>Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anoxia</b> <b>177x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastatic carcinoma to lungs</b> DUE TO (c) <b>Carcinoma of Prostate</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>6 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1 May</b> , 19 <b>59</b> , to <b>28 October</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>28 October</b> , 19 <b>59</b> , and that death occurred at <b>5:45 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>R. T. Brooks Jr.</b>		M.D. <b>U.S. Naval Hospital, Bethesda Md. 10-29-59</b>	
PHYSICIAN'S NAME (Type) <b>Robert T. Brooks Jr.</b>		<b>U.S. Naval Hospital, Bethesda, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-30-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Pumphrey</b>		24. REC'D BY REGISTRAR <b>NOV 2 '59</b>	
ADDRESS <b>7557 Wisconsin Ave. Bethesda Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

Page 4 After death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11661

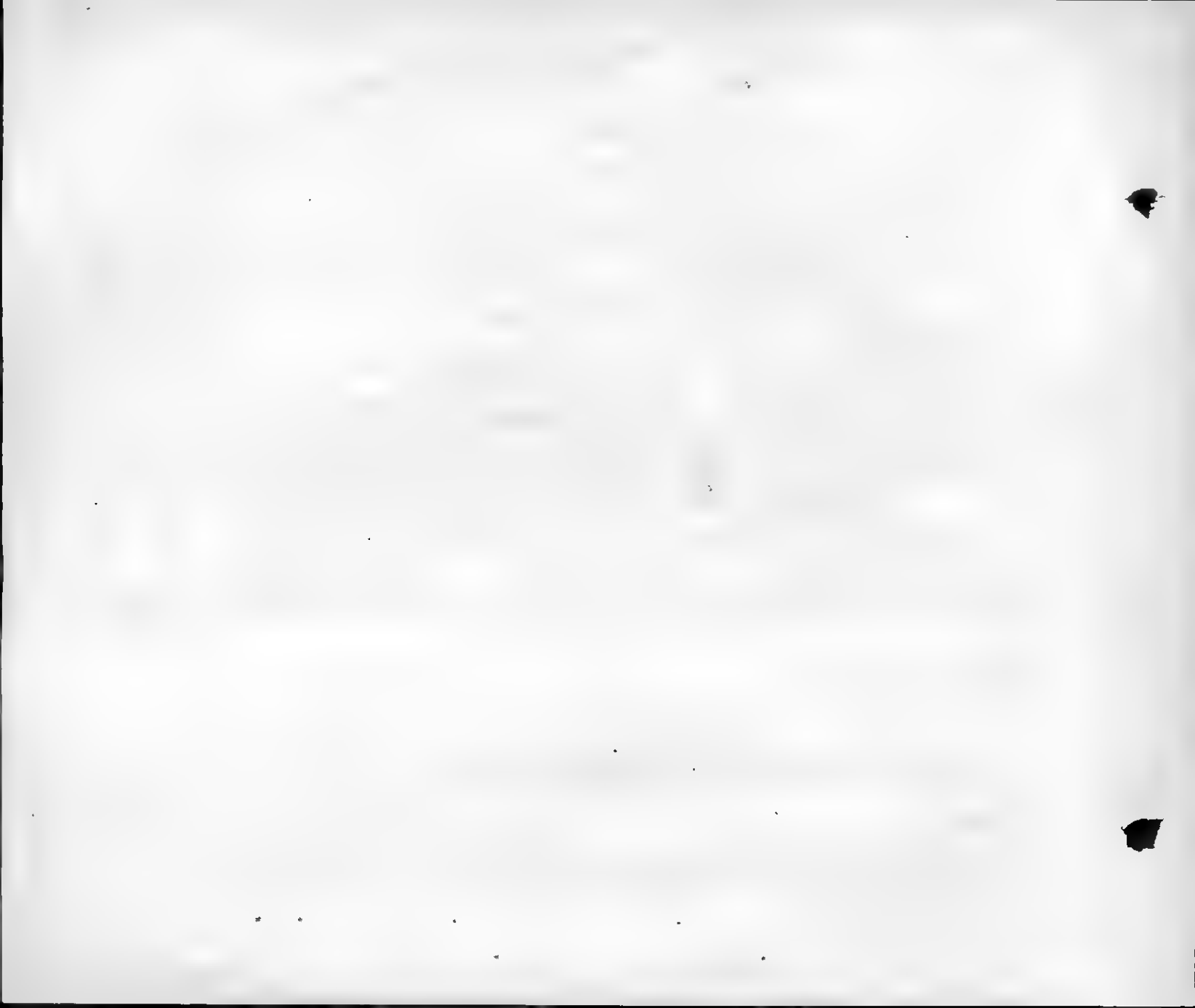
## CERTIFICATE OF DEATH

11635

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>2 wks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City, Md. R.F.D. 2 12</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>				d. STREET ADDRESS <u>Folly Quarter Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Otto</u> Middle <u>C.</u> Last <u>Rost</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>21</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 30. 1870</u>		9. AGE (In years last birthday) <u>89</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Not available</u>				14. MOTHER'S MAIDEN NAME <u>Not available</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>57-12-3561A</u>		17. INFORMANT <u>Daughter Mrs. S. Geo. E. Miller</u> <u>3659 records RFD 2 Ellicott City, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery arteriosclerosis</u> DUE TO (c) <u>20 years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Apr 12 1958</u> to <u>Oct 21 1959</u> , that I last saw the deceased alive on <u>Oct 19 1959</u> , and that death occurred at <u>6:34</u> M., from the causes and on the date stated above							
ACTUAL SIGNATURE <u>Charles S. Whitaker</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>CLARKSVILLE, MD. 10/21/59</u>			
PHYSICIAN'S NAME (Type) <u>CHARLES S. WHITAKER, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/24/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Witzke Funeral Dir. 4101 Edmondson Ave.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

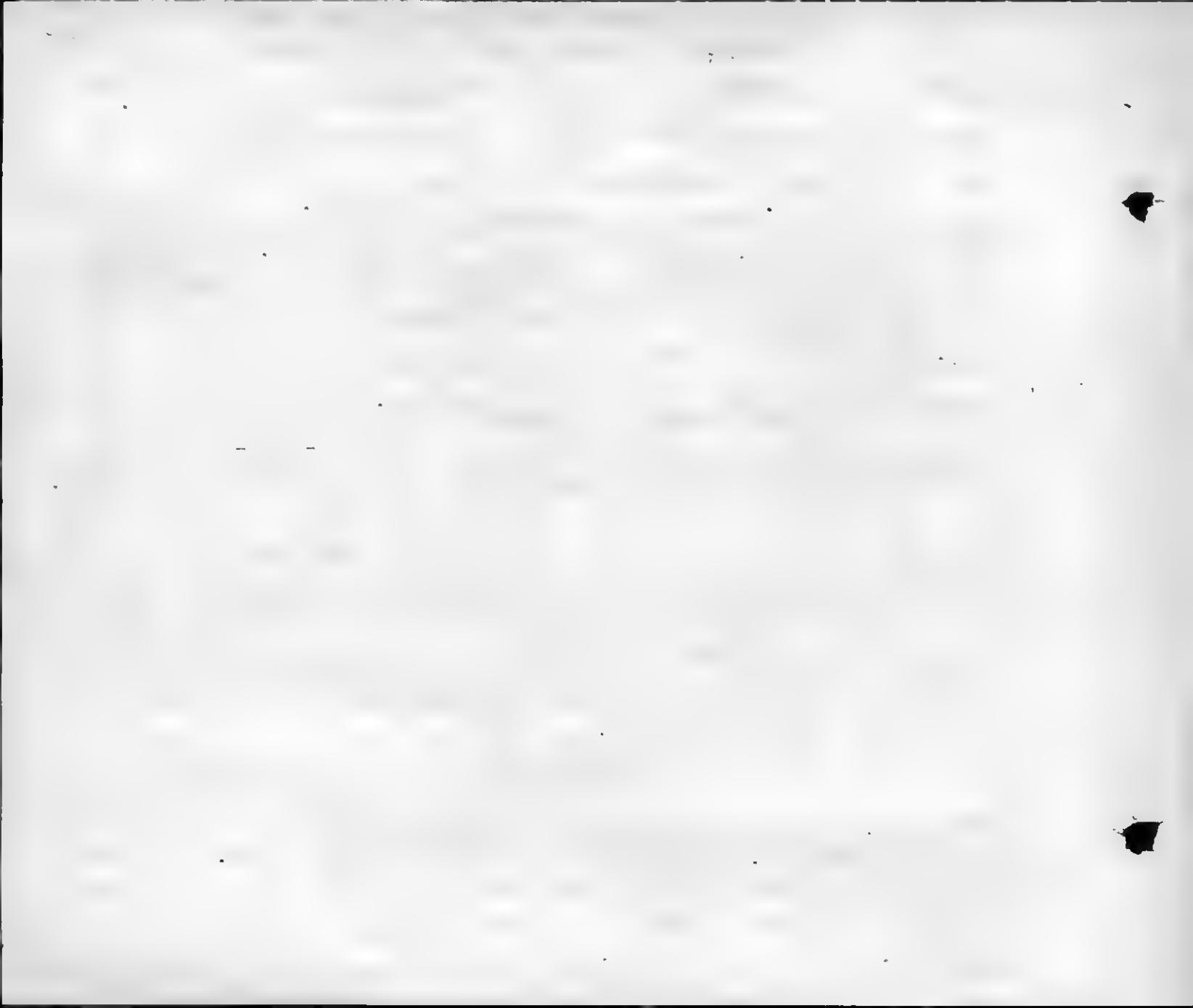
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11636

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <span style="float: right;">11662</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>9111 River Rd.</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>9111 River Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mervin</b> Middle <b>White</b> Last <b>Rowell</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>16</b> , Year <b>1959</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/31/1901</b>	
9. AGE (in years last birthday) <b>58</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manuf. Representative</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Manufacturing</b>		11. BIRTHPLACE (State or foreign country) <b>Minnesota</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Charles Henry Rowell</b>				14. MOTHER'S MAIDEN NAME <b>Annie E. Marcey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>		17. INFORMANT <b>Greta Mason Rowell-wife-same as 2d</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>4001</b> (c), stating the underlying cause lost. DUE TO						INTERVAL BETWEEN ONSET AND DEATH <b>9 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				<b>Oct. 18, 1959</b>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>10/17/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>DATE OCT 19 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the date, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

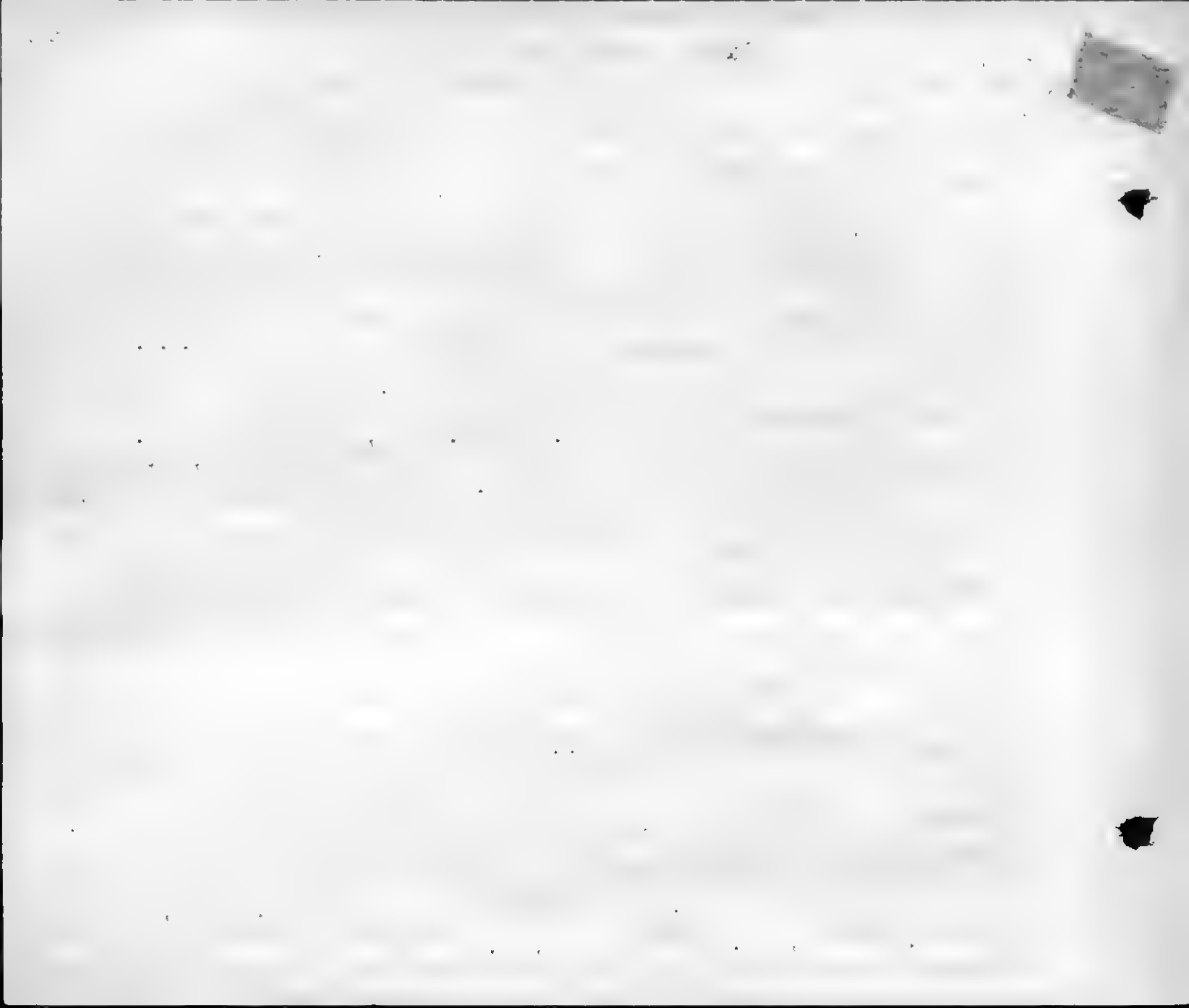
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11637

## 11663 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b <b>1 month</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1415 CRESTRIDGE DRIVE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>AGNES First GLESSNER Middle RYDER Last</b>		4. DATE OF DEATH Month <b>October</b> Day <b>6</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/16/82</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>MINNESOTA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FRANK GLESSNER</b>		14. MOTHER'S MAIDEN NAME <b>MARY E. CROCKER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Mr. James D. Kline, 1415 Crestridge Dr.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic malignancy of liver</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Adenocarcinoma of the colon</b> DUE TO (c) <b>8 months</b> INTERVAL BETWEEN ONSET AND DEATH <b>8 months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June, 1959</b> to <b>October, 1959</b> , that I last saw the deceased alive on <b>October 5, 1959</b> , and that death occurred at <b>10:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Sydney Leventhal, M.D. 7210 Collesville Rd. Silver Spring, Md. 10/6/59</b>			
ACTUAL SIGNATURE <b>SYDNEY LEVENTHAL</b>		PHYSICIAN'S NAME (Type) <b>SYDNEY LEVENTHAL</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		22b. DATE THEREOF <b>10/6/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CREMATORY</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Liska</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 7 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>William E. Kline</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11664

Item 7 of 1-1-60 et

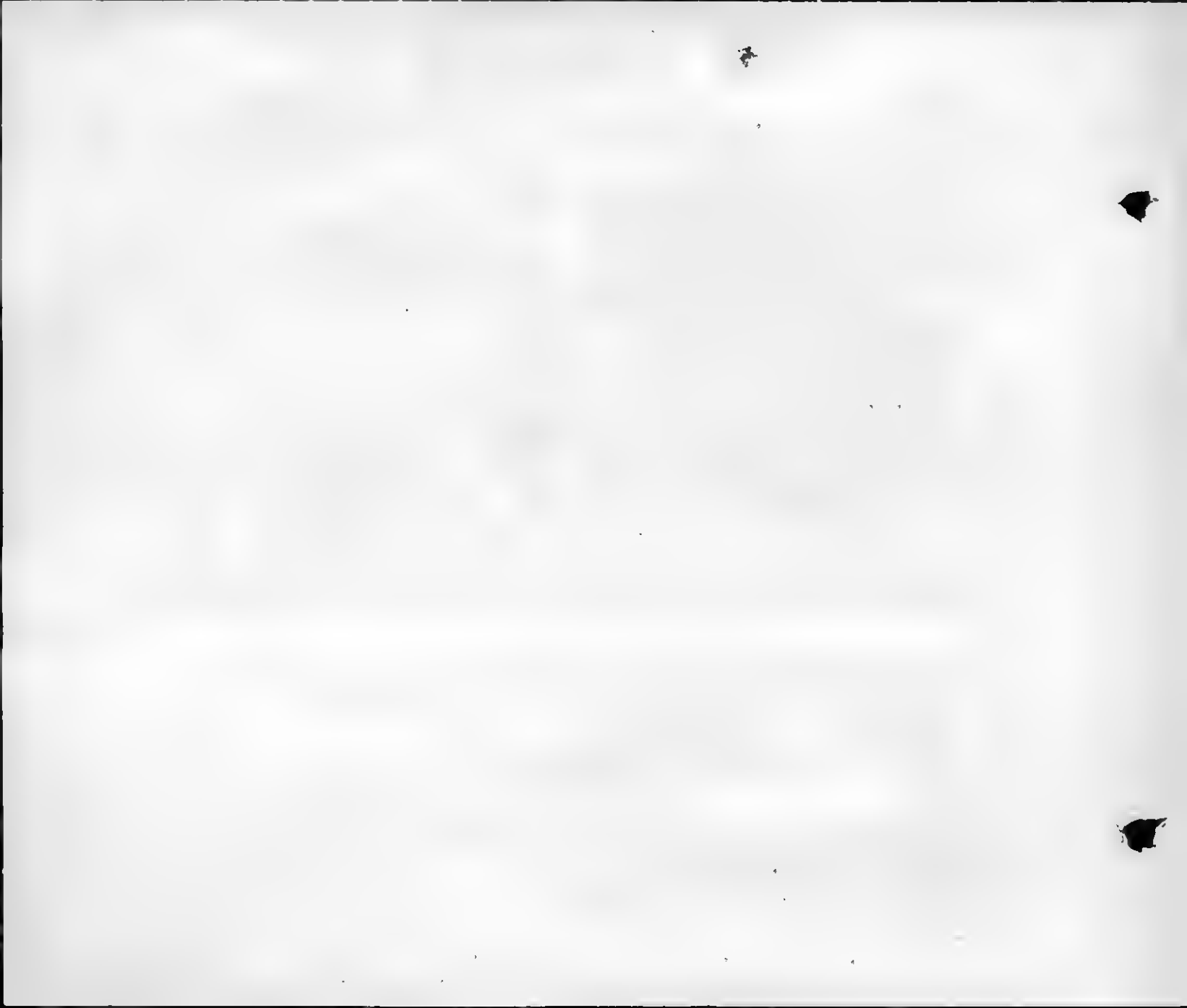
## CERTIFICATE OF DEATH

11638

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montg.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived) If institution: Residence before admission a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, rural, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>South Ave., Annapolis, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Marilee West</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Reuben</u> Middle <u>Salter</u> Last <u>Rubens</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>23</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 28-1907</u>
9. AGE (In years last birthday) <u>76</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>3</u> Days <u>25</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cabinet maker</u>	
11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>England</u>	
13. FATHER'S NAME <u>A.C. Salter</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Rawliston</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-07-8189</u>	
17. INFORMANT <u>Marilee West</u>		Address <u>Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Chronic Myocardial Disease</u> DUE TO (c) <u>Stenosed Coronary Arteries</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 22, 1958</u> to <u>Oct. 23, 1959</u> , that I last saw the deceased alive on <u>Oct. 15, 1959</u> , and that death occurred at <u>8 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John S. Rogers</u> M.D.		ADDRESS (Street, city or town, state) <u>1919 Seminary Rd. Silver Spring, Md.</u> DATE SIGNED <u>Oct 23, 1959</u>	
PHYSICIAN'S NAME (Type) <u>John S. Rogers</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-27-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest G. Gartner</u>		ADDRESS <u>Calverton, Md.</u>	
24a. REC'D BY REGISTRAR <u>OCT 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





11525

## CERTIFICATE OF DEATH

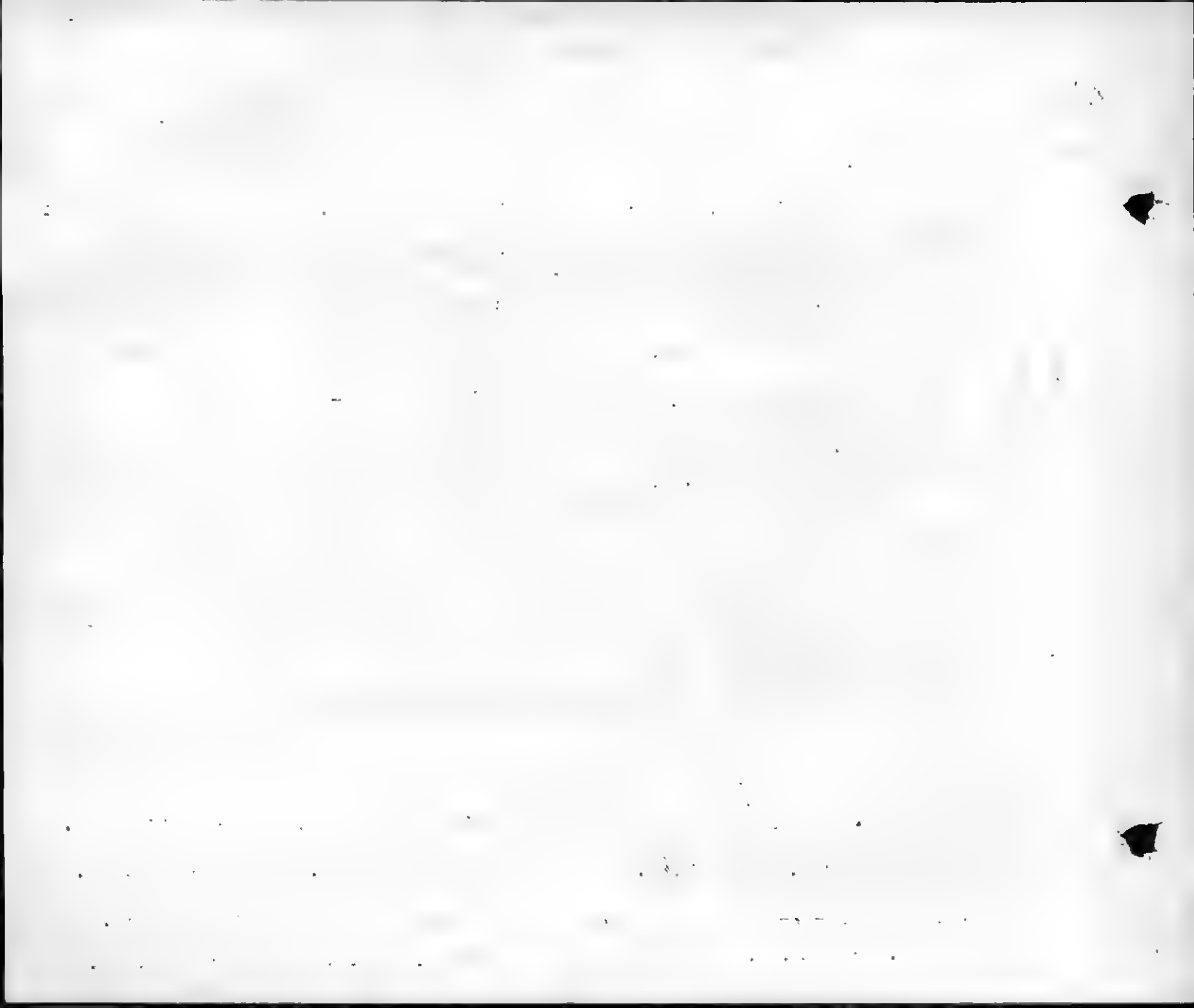
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park,</b>		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park,</b>		d. STREET ADDRESS <b>6418 Sligo Mill Rd.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Schaffer</b>		4. DATE OF DEATH Month Day Year <b>October 11, 19 59</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 10, 1959</b>		9. AGE (In years last birthday) yrs. <b>25</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>America</b>		13. FATHER'S NAME <b>Ramon Samuel Schaffer</b>		14. MOTHER'S MAIDEN NAME <b>Muriel - Wolk</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO <b>no</b>		17. INFORMANT <b>father</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4330 DUE TO</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) DUE TO <b>Benign Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month. Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED		ACTUAL SIGNATURE <b>Raymond F. Chinn</b> M.D. <b>925 Pershing Dr., Silver Spring, Md.</b>	
21. PHYSICIAN'S NAME (Type) <b>Raymond F. Chinn, M. D.</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation 10-12-59</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>Washington Sanitarium &amp; Hospital, Takoma Park, Md.</b>		22d. LOCATION (City, town, or county) (State)		22e. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Hare, M. D. Washington Sanitarium and Hospital, Takoma Park 12, Md.</b>		22f. REC'D BY REGISTRAR <b>OCT 20 59</b>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon portions. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

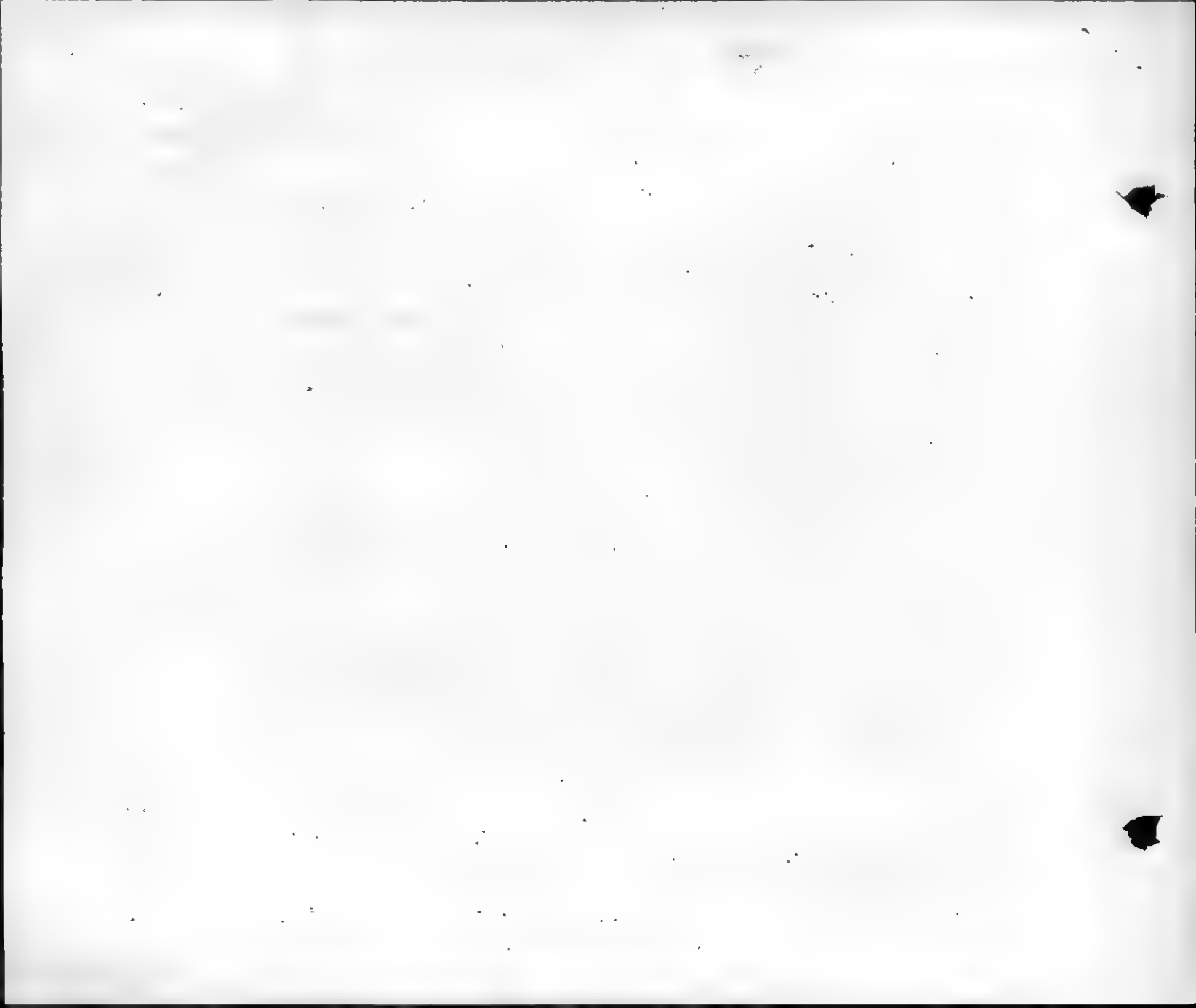
11665

## CERTIFICATE OF DEATH

Reg. Dist. No.

11640

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>26</u> <u>das</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Kensington,</u> d. STREET ADDRESS <u>3208 Ferndale St.,</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <u>Louise</u> <u>Shheer</u>		4. DATE OF DEATH Month Day Year <u>10</u> <u>16</u> <u>19 59</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/18/17</u>	9. AGE (In years lost birthday) yrs. <u>42</u>	10. IF UNDER 1 YEAR Months <u>2</u> Days <u>28</u>	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>John O'Donnoghue</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Schmitt</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT Address <u>Wilmer P. Scheer - Husband - Item #2</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Malnurtition</u> DUE TO <u>+ electrolyte imbalance</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Carcinoma of the pancreas</u> DUE TO (c) <u>12 months</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb 1</u> , 19 <u>57</u> , to <u>Oct 16</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct 16</u> , 19 <u>59</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Horace W. Bernton</u> <u>10511 Summit Ave.</u> <u>10-16-59</u> <u>Kensington, Md.</u>						
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <u>Horace W. Bernton</u>				
22a. BURIAL, CREMATION, REMOVAL. (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-19-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Pumphrey, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 20 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11666

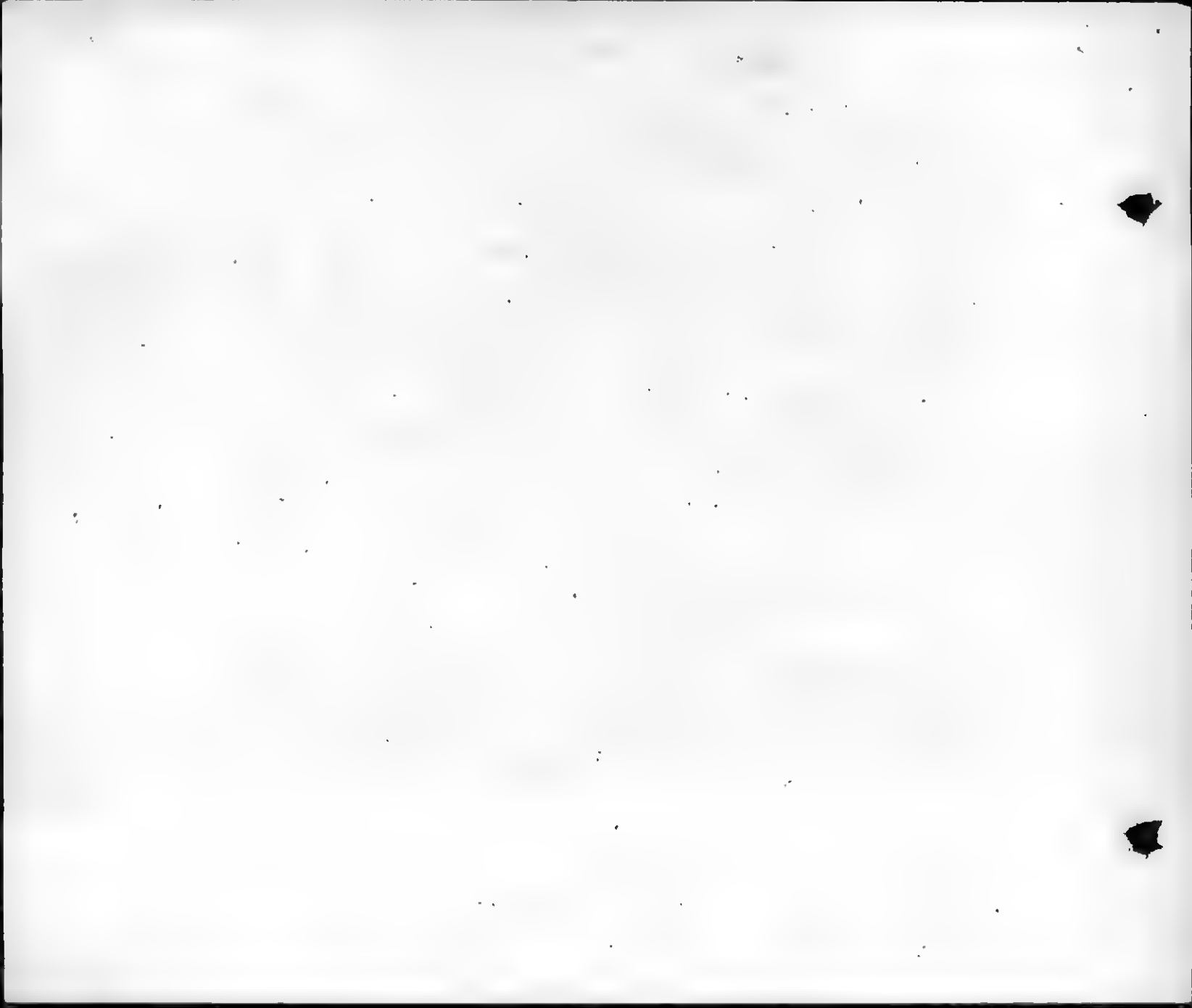
## CERTIFICATE OF DEATH

Reg. Dist. No. 11641

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>Rockville</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> d. STREET ADDRESS <b>4809 Wyaconda Road</b>	
3. NAME OF DECEASED (Type or print) First <b>MELANIE</b> Middle <b>DAWN</b> Last <b>SCHNEIDER</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>3</b> Year <b>19 59</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 3, 1959</b>
9. AGE (In years last birthday) <b>5</b>		10. IF UNDER 1 YEAR: Months <b>-</b> Days <b>-</b> Hours <b>-</b> Min <b>5</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>	
11. BIRTHPLACE (State or foreign country) <b>Bethesda, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles William Schneider</b>		14. MOTHER'S MAIDEN NAME <b>Audrey L. Bond</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Charles W. Schneider - Item #2-Father</b>		Address <b>Item #2-Father</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Premature 3rd/2 Spina</b> DUE TO (b) <b>Bilateral Meningocele</b> DUE TO (c) <b>(7th mo) (Serto L.A.B.)</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost			INTERVAL BETWEEN ONSET AND DEATH <b>5-10 min.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. <b>10/3/59</b> Day. <b>4:30 PM</b> Year <b>19</b> Hour <b>4:30</b> o. m. <b>PM</b> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>8/1/59</b> to <b>10/3/59</b> , that I last saw the deceased alive on <b>10/3/59</b> , and that death occurred on <b>10/3/59</b> at <b>4:30 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert A. Pumphrey</b> M.D.		DATE SIGNED <b>10/3/59</b>	
PHYSICIAN'S NAME (Type) <b>Robert A. Pumphrey</b>		M.D. <b>Bethesda, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-5-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>OCT 6 '59</b>	
ADDRESS <b>Bethesda, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur A. Kline</b>	

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ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.  
VS A15 (4)  
15M 9/58



## CERTIFICATE OF DEATH

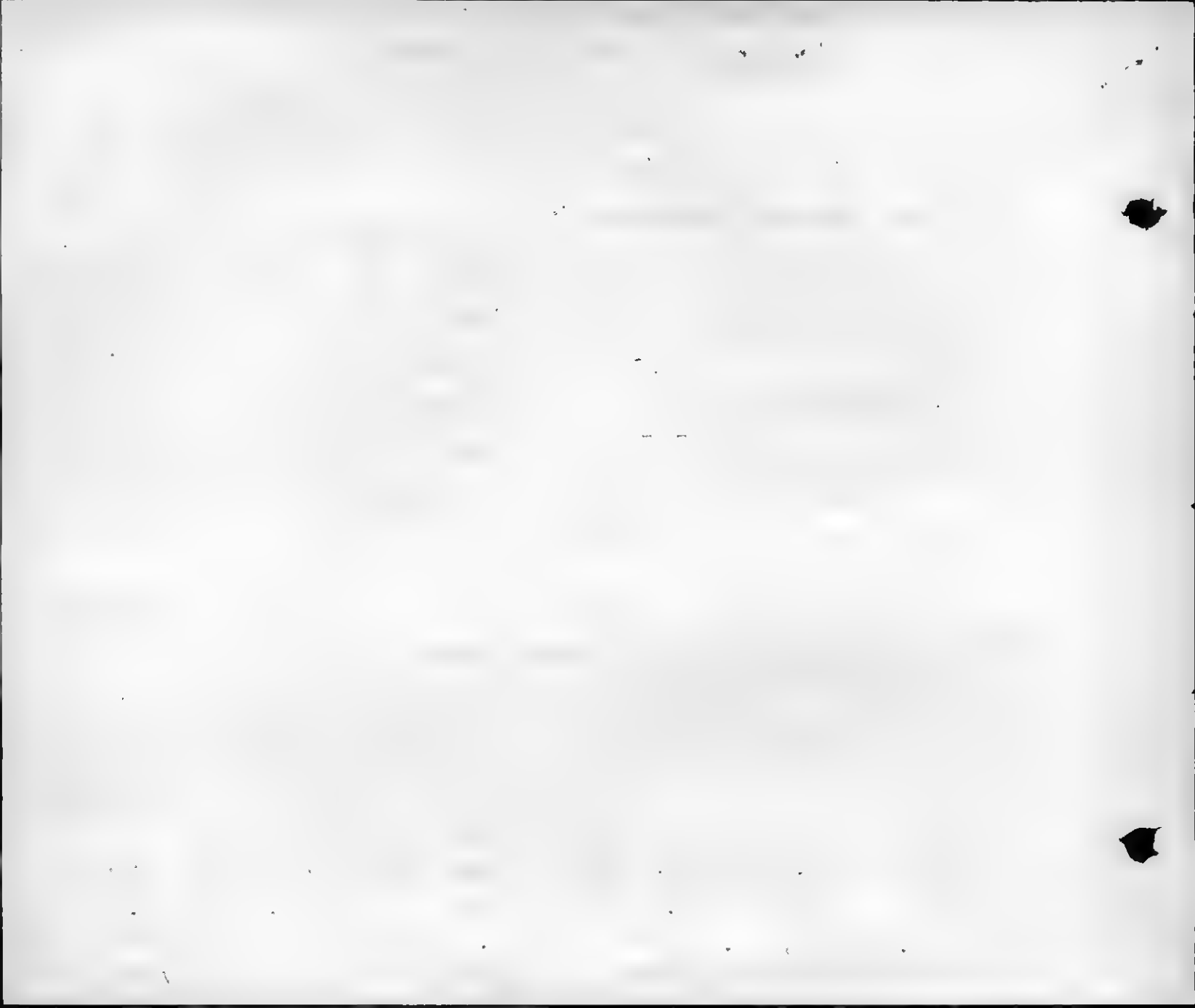
11667

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>4 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital, Inc.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Douglas</b> Last <b>Scott</b>		4. DATE OF DEATH Month <b>10</b> Day <b>1</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5.7.84</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months <b>75</b> Days <b>75</b> Hours <b>75</b> Min <b>75</b>	IF UNDER 24 HRS Months <b>75</b> Days <b>75</b> Hours <b>75</b> Min <b>75</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bank Supplies &amp; Equipment</b>	
11. BIRTHPLACE (State or foreign country) <b>Scotland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Thomas Kennedy Scott</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ann Duncan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <b>107-05-6615-4</b>	
17. INFORMANT Address <b>Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bilateral Bronchopneumonia</b> DUE TO <b>and Tracheobronchitis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of Prostate</b> (c) <b>Carcinoma of Prostate</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>4/2/59</b> , 19 <b>59</b> , to <b>10/1</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>10/1</b> , 19 <b>59</b> , and that death occurred at <b>7:50 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>[Signature]</b>		DATE SIGNED <b>10.2.59</b>	
PHYSICIAN'S NAME (Type) <b>J. W. Bird, M. D.</b>		ADDRESS (Street, city or town, state) <b>Sandy Spring, Md.</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>CREMATION</b>	22b. DATE THEREOF <b>10/2/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crematory</b>	22d. LOCATION (City, town, or county) (State) <b>Prince Geo. County, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Liska</b>		24a. REC'D BY REGISTRAR <b>DATE OCT 5 1959</b>	
24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO HOSPITALS: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11526

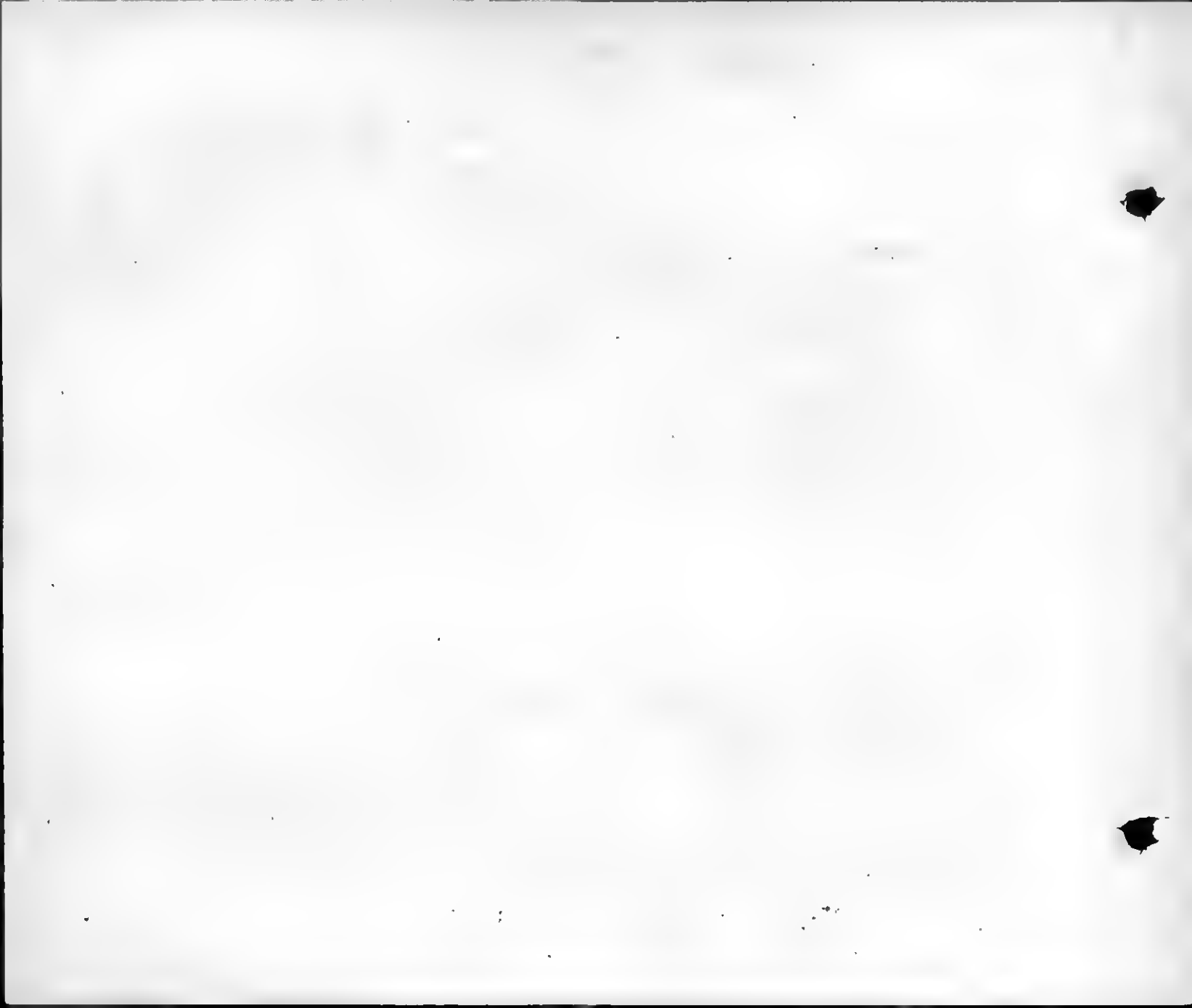
## CERTIFICATE OF DEATH

Reg. Dist. No.

11643

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>8 days.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. San + Hosp.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Gaithersburg</u>	
		f. d. STREET ADDRESS <u>Rt 1 Box 46</u>	
3. NAME OF DECEASED (Type or print) <u>Best</u> First Middle Last <u>Seek.</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>24</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-20-89</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dairy Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard Seek</u>		14. MOTHER'S MAIDEN NAME <u>Isabelle Cole</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u> INFORMANT <u>Chart.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. <u>Chronic Myocardial Infarction, Aortic Insufficiency</u> DUE TO <u>Atherosclerosis</u> (c) <u>Other</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Myocardial Infarction, Aortic Insufficiency</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>6:25</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. H. Wolohin M.D.</u> M.D.		ADDRESS (Street, city or town, state) <u>500 Underwood St NW</u> DATE SIGNED <u>10/24/59</u>	
PHYSICIAN'S NAME (Type) <u>W. H. WOLOHON M.D.</u>		<u>Wash DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct. 27 59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>George Washington</u>	22d. LOCATION (City, town, or county) (State) <u>Adelphi Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Roy W. Barber</u> ADDRESS <u>Saylorsville Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 28 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11668

## CERTIFICATE OF DEATH

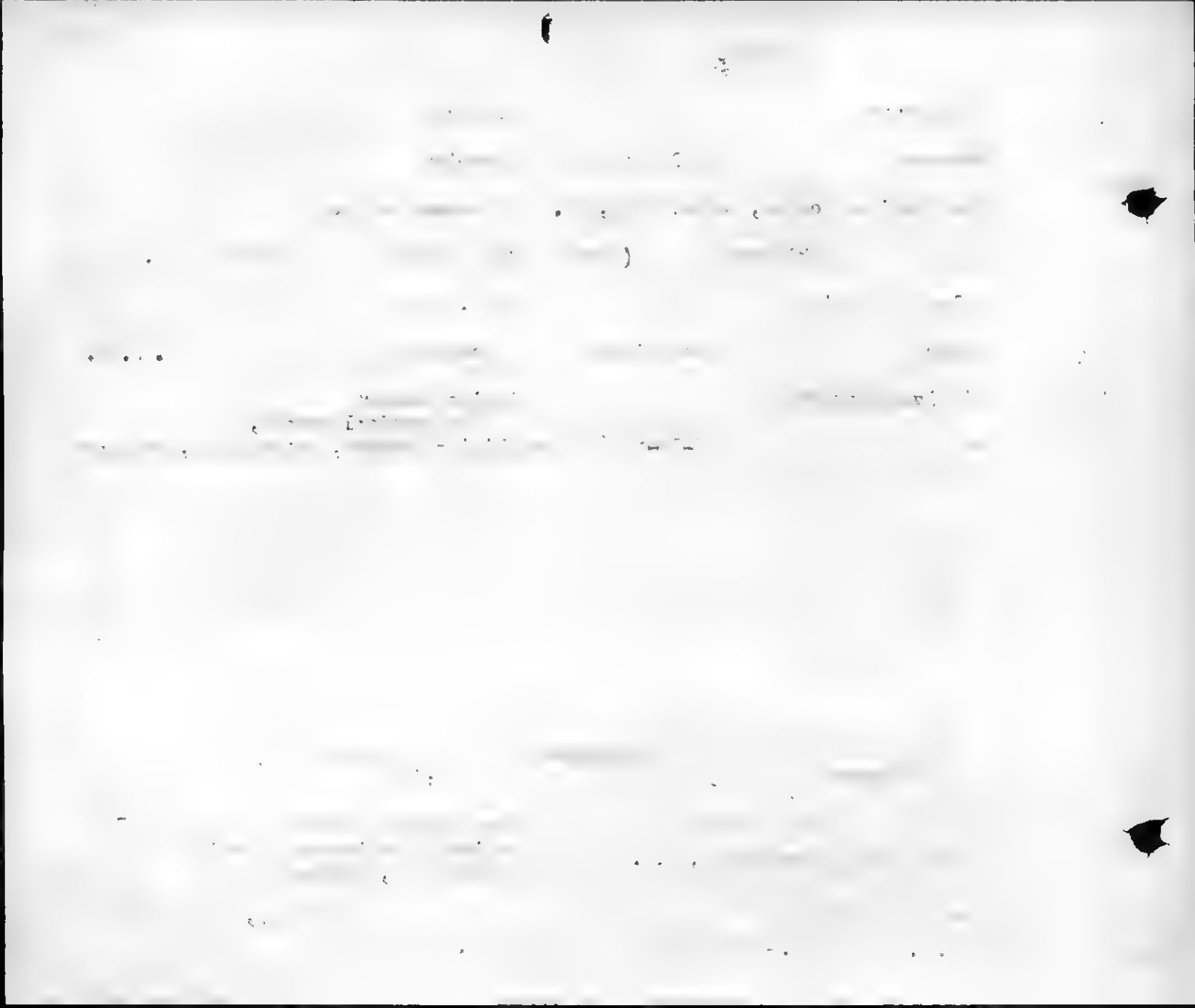
Reg. Dist. No.

11644

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Kentucky</b> b. COUNTY <b>Crummies</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>16 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>No street address</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Childres</b> Middle <b>(None)</b> Last <b>Shackleford</b>				4. DATE OF DEATH Month <b>October</b> Day <b>6</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 3, 1904</b>	
9. AGE (In years last birthday) <b>55</b> yrs		IF UNDER 1 YEAR Months <b>55</b> Days <b>55</b> Hours <b>55</b> Min.		IF UNDER 24 HRS Months <b>55</b> Days <b>55</b> Hours <b>55</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Mining</b>		11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>William Shackleford</b>				14. MOTHER'S MAIDEN NAME <b>Lavina Ledford</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO <b>103-10-6656</b>			
17. ADDRESS <b>The Medical Record, The Clinical Center, Bethesda 14, Maryland</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aortic stenosis</b> DUE TO <b>Rheumatic heart disease,</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>inactive unknown</b> (b) <b>inactive unknown</b> (c) <b>inactive unknown</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Transventricular aortic valvulotomy</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>September 20 1959</b> , to <b>October 6, 1959</b> , that I last saw the deceased alive on <b>October 6, 1959</b> , and that death occurred at <b>12:50 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>10-6-59</b> DATE SIGNED <b>10-6-59</b>							
ACTUAL SIGNATURE <b>Lazar Greenfield</b>				M.D. <b>The Clinical Center</b>			
PHYSICIAN'S NAME (Type) <b>Lazar Greenfield, M.D.</b>				National Institutes of Health <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>				22b. DATE THEREOF <b>10/7/59</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>--</b>				22d. LOCATION (City, town, or county) (State) <b>Crummies, Kentucky</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.-2901 14th St., N.W. Wash. DC</b>				24a. REC'D BY REGISTRAR DATE <b>OCT 8 '59</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur A. Hines</b>							

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11669

## CERTIFICATE OF DEATH

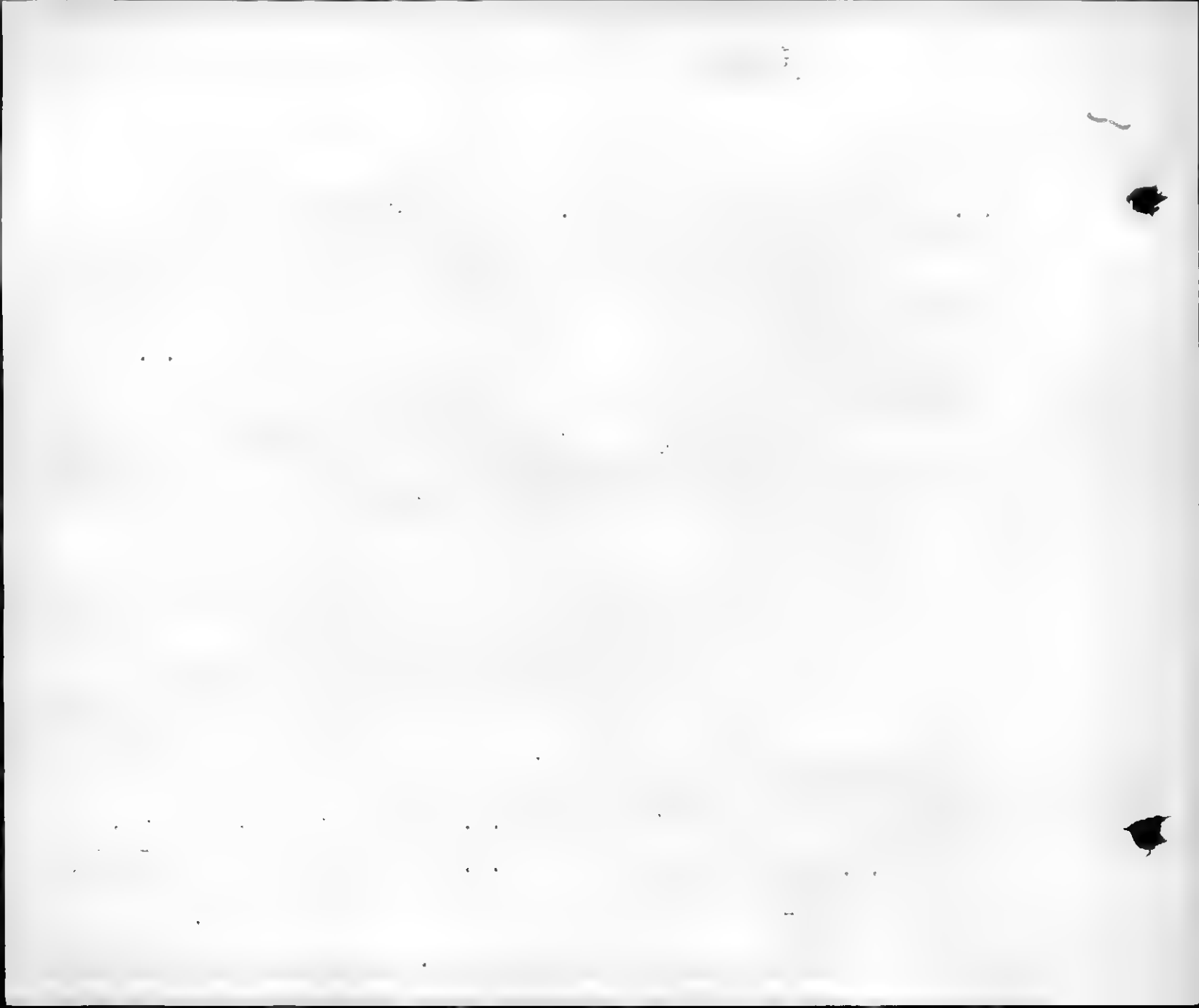
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>30 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Manassas</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Manassas</b> d. STREET ADDRESS <b>438 Stuart Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Ruth Marie SHOEMAKE</b>			4. DATE OF DEATH Month Day Year <b>October 23 19 59</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-8-17</b>	9. AGE (In years last birthday) <b>42 yrs</b>	10. IF UNDER 1 YEAR Months Days Hours Min. <b>42</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			13. FATHER'S NAME <b>August MICHEL</b>		
14. MOTHER'S MAIDEN NAME <b>Anna EYSER</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO <b>None</b>			17. INFORMANT Address <b>(Husband) Arthur L Shoemake Same as #2</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>581.0</b> DUE TO <b>Primary Biliary Cirrhosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO					INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <b>23 Sept.</b> , 19 <b>59</b> , to <b>23 October 1959</b> , that I last saw the deceased alive on <b>23 October</b> , 19 <b>59</b> , and that death occurred at <b>5:50 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda, Md</b> ACTUAL SIGNATURE <b>R. G. Muth</b> M.D. <b>U.S. Naval Hospital, Bethesda, Md</b> PHYSICIAN'S NAME (Type) <b>R.G. MUTH LT MC USN</b> <b>U.S. Naval Hospital, Bethesda, Md.</b> <b>10-23-59</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-27-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Baker and Son 314 West Street Manassas, Va</b>		24a. REC'D BY REGISTRAR <b>OCT 27 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Shoemake</b>		

1

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 4 hours after death. If any delay is necessary, please excuse the delay, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

Item 18 Film 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11646

11670

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>6733 Fairfax Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Sarah Davis Smith</u>		4. DATE OF DEATH <u>10-15-1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-3-'57</u>
9. AGE (In years last birthday) <u>12 days</u>		IF UNDER 1 YEAR: Months <u>12</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Thomas Smith</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Flynn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Father</u>		Address <u>Thomas Smith</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intrapneumonic hemorrhage, defuse, ilioptatic</u> <u>765.0</u> DUE TO (b) <u>(Found dead in bed)</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>10-16-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>10/20/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>DATE OCT 19 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

2 2 X 15

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211



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**11671** **CERTIFICATE OF DEATH**

11647

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>DOA</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>STEVEN LAURIE SMITH</u>				4. DATE OF DEATH Month Day Year <u>OCT 7 1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 19, 1959</u>	
9. AGE (In years last birthday) <u>4 1/2</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>COLEMAN SMITH</u>		14. MOTHER'S MAIDEN NAME <u>ELAINE CRAWFORD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		INFORMANT Address <u>Mr. Coleman Smith, 12005 St. Dunston Rd. Wheaton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>2 Bronche Pneumonia</u> <u>441X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>1. Asphyxiation</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) _____					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 6</u> , 19 <u>59</u> , to <u>Oct 6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct 6</u> , 19 <u>59</u> , and that death occurred at <u>7<sup>25</sup></u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8200 16th St., N.W. Washington, D.C.</u> DATE SIGNED <u>10/7/59</u>							
ACTUAL SIGNATURE <u>Arthur D. Davis</u> M.D.		FURNAL DIRECTOR'S SIGNATURE <u>RAYMOND A. ZIEGLER</u>					
PHYSICIAN'S NAME (Type) <u>ARTHUR D. DAVIS</u>							
22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/8/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WALTER E. LUMPHREY, INC.</u>		ADDRESS <u>SILVER SPRING, MD</u>		24a. REC'D BY REGISTRAR <u>DATE OCT 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur D. Davis</u>	

DR. BROCHART NOTIFIED

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11648

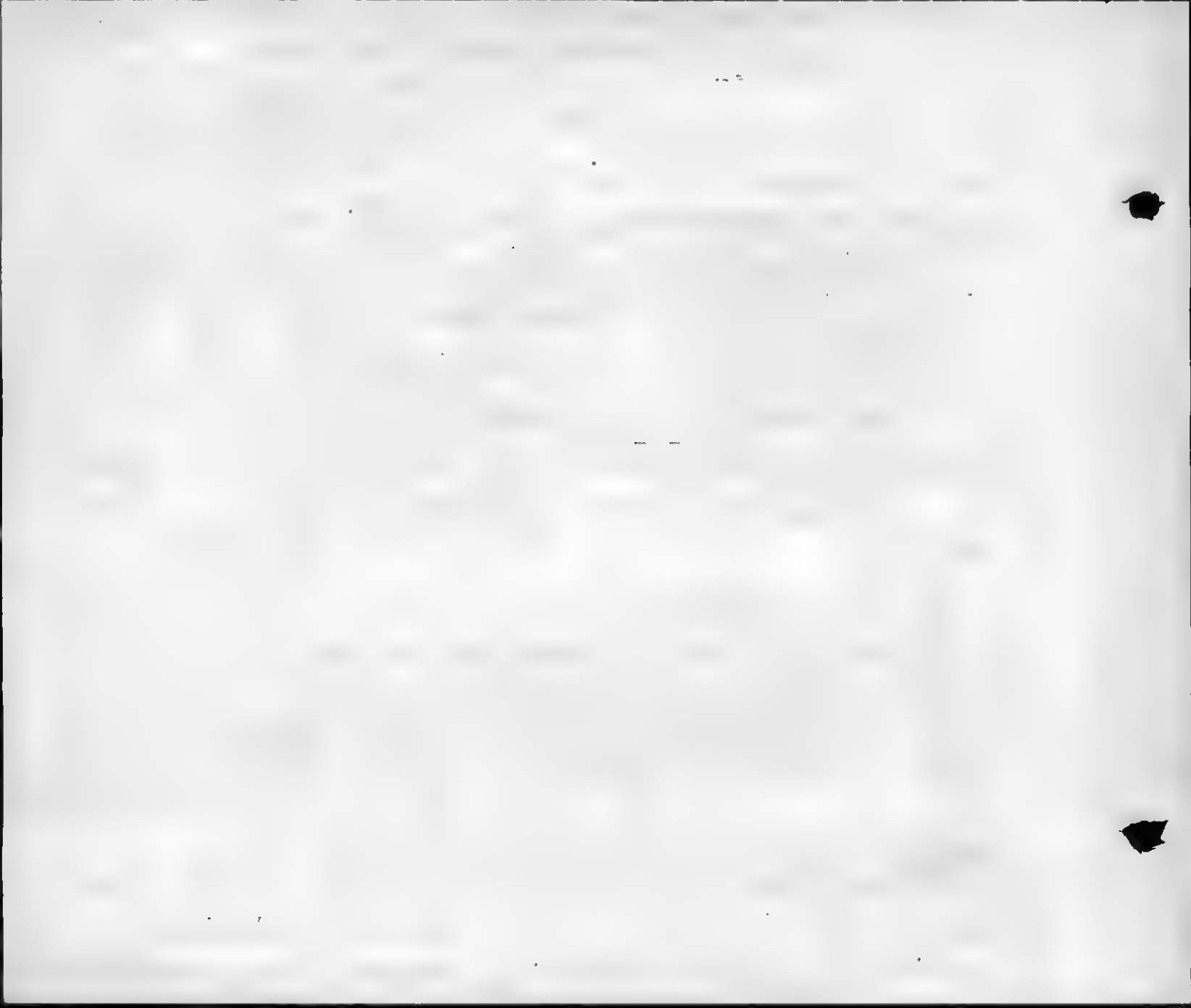
Reg. Dist. No.

11672

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN TB <u>40 min.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg,</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>Warfield Rd. RFD #2</u>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Warren</u> Middle <u>Wesley</u> Last <u>Smith</u>				<b>4. DATE OF DEATH</b> Month <u>10</u> Day <u>19</u> Year <u>19 59</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>1/11/01</u>		<b>9. AGE</b> (In years last birthday) <u>58</u> yrs.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>D.C. Insurance retired</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>retired</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>N.Y.</u>			
<b>13. FATHER'S NAME</b> <u>Warren Smith</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Mavis Edwards</u>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b> <u>577-54-1091</u>		<b>17. INFORMANT</b> <u>Hazel Smith (wife)</u> Address <u>Stn 2</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour _____ a. m. _____ p. m.      Month, Day, Year _____ 19____	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>			
<b>21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b> <u>Frank J. Bruchart</u> M.D.			<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				
<b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Bruchart</u>			<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			<b>DATE SIGNED</b> <u>10-19-59</u>				
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>Oct 23, 1959</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill Cemetery</u>			
<b>22d. LOCATION (City, town, or county) (State)</b> <u>Suitland, Md.</u>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <u>F. Gasch's Sons Hyattsville, Md.</u>					
<b>24a. REC'D BY REGISTRAR</b> DATE <u>OCT 22 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>C. Stuart S. Krum</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



Reg. Dist. No.

### MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>		c. LENGTH OF STAY IN 1b <u>20 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium &amp; Hospital</u>				e. STREET ADDRESS <u>5816 Greentree Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elizabeth Rose Sperandio</u>				4. DATE OF DEATH Month Day Year <u>Oct. 27 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/24/85</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min <u>0 3</u>		IF UNDER 24 HRS. Months Days Hours Min <u>0 3</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Patricella</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>William J. Eminhizer - son-in-law - 2d</u>		Address <u>SAME AS</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>5 weeks</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October, 1958</u> to <u>10/27/1959</u> , that I last saw the deceased alive on <u>10/27/1959</u> , and that death occurred at <u>8:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Russell B. Arnold</u>		ADDRESS (Street, city or town, state) <u>M.D. 8801 Coleville Road, Silver Spring, Md.</u>					
PHYSICIAN'S NAME (Type) <u>Russell B. Arnold</u>		DATE SIGNED <u>10/27/59</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/31/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>Oct 29 1959</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

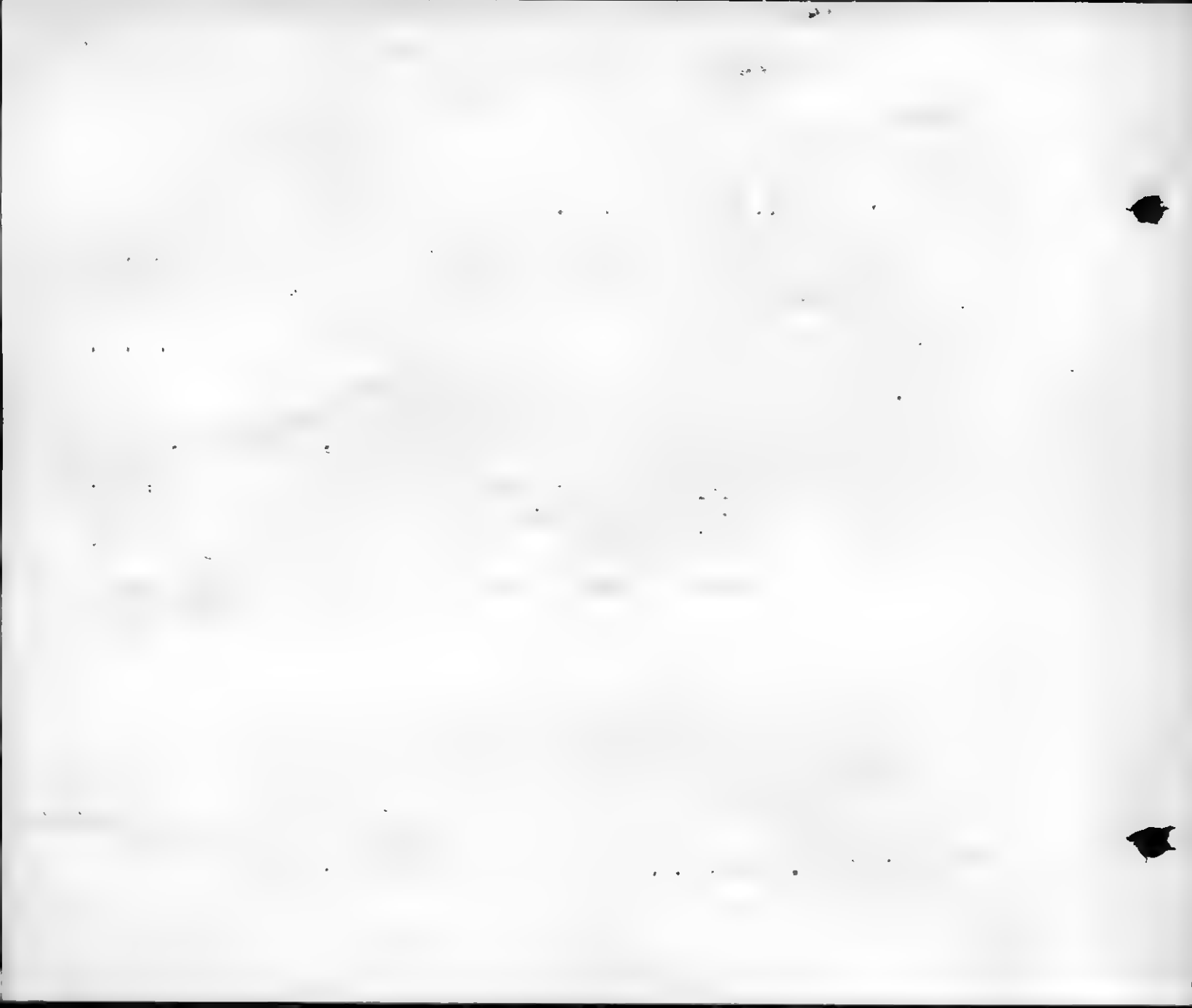
Reg. Dist. No.

11673

11650

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>8 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY <b>Union</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elizabeth</b> d. STREET ADDRESS <b>18 A Pioneer Home</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Danny</b> Middle <b>Benny</b> Last <b>Stewart</b>				4. DATE OF DEATH Month <b>October</b> Day <b>12</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 2, 1948</b>	
9. AGE (In years last birthday) <b>11</b> yrs.		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>12</b> Hours <b>19</b> Min <b>59</b>		11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>	
13. FATHER'S NAME <b>James T. Stewart</b>				14. MOTHER'S MAIDEN NAME <b>Mary Stewart</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b> DUE TO <b>Status, postoperative</b> (b) <b>Cardiac Surgery</b> DUE TO <b>Congenital Heart Disease</b> (c) <b>Life</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Life</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>October 4, 1959</b> to <b>October 12, 1959</b> , that I last saw the deceased alive on <b>October 12, 1959</b> , and that death occurred at <b>8:50 P.</b> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>William W. Pfaff, M.D.</b>				ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b> DATE SIGNED <b>10/13/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>10-17-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ROSEHILL Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Linden Union NJ</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B.M. Nesbitt</b>				24a. REC'D BY REGISTRAR <b>Elizabeth NJ</b> DATE <b>OCT 16 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>			

MEDICAL CERTIFICATION





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11535

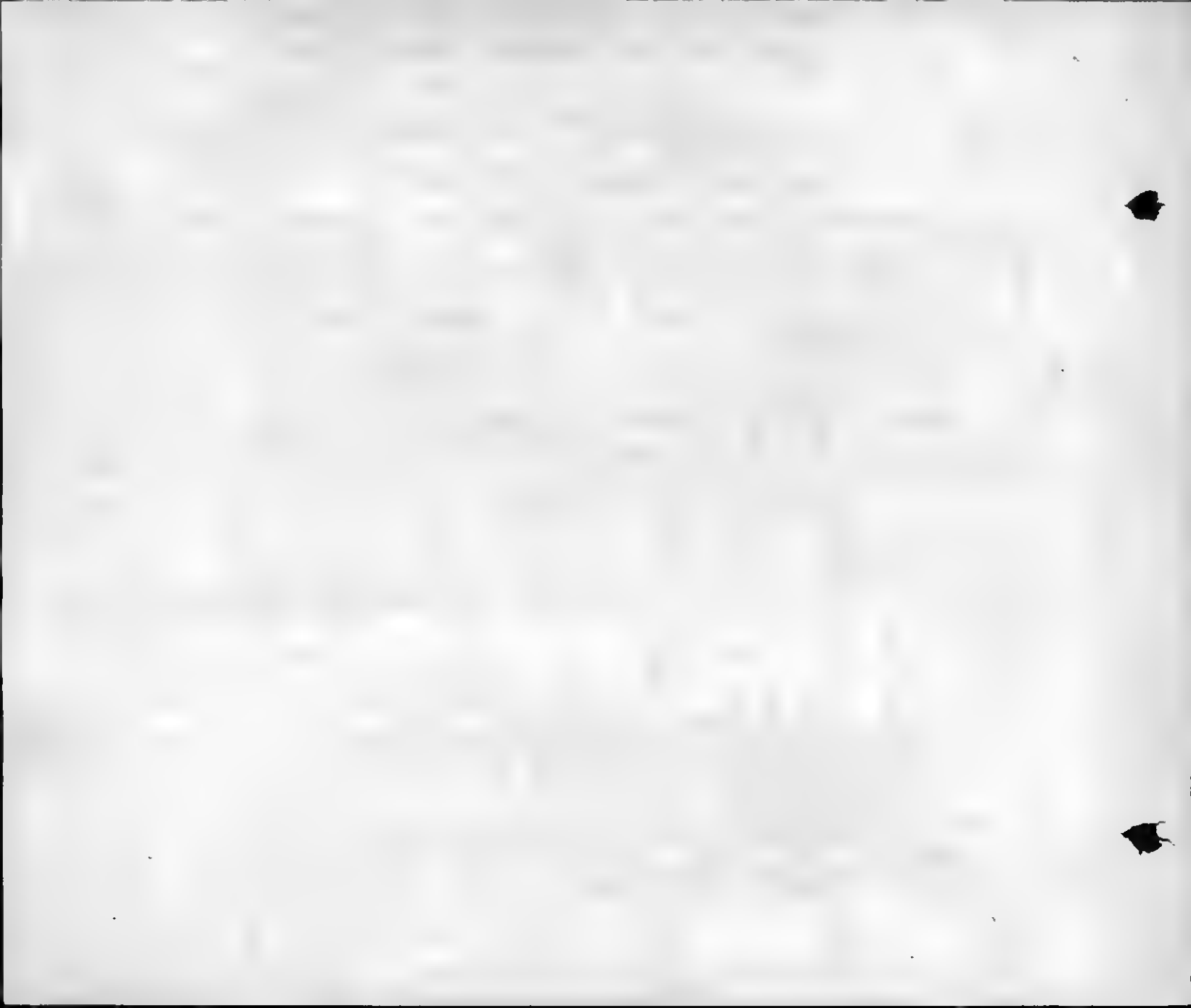
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11651

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>monty</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>4 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Board of Education office</u>				d. STREET ADDRESS <u>4501 Furman Ct.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>mae</u> Middle <u>Kessinger</u> Last <u>Stewart</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>6</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-10-1918</u>	
9. AGE (In years last birthday) <u>40</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>26</u>		IF UNDER 24 HRS. Hours <u>26</u> Min.			
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sec</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Board of education</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Walter O. Kessinger</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Kirk</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT Address <u>Sheridan Stewart - Item #2-Husband</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bath room</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Brosch</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10-6-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur.-Trans.</u>		22b. DATE THEREOF <u>10-10-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oakwood Cemetery</u>		22d. LOCATION (City, town, or county) _____ (State) _____ <u>Mercer County, W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur A. Hines</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



11674

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>5 1/2 HRS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>SUBURBAN HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ROGER</u> Middle <u>J</u> Last <u>STICHT</u>		4. DATE OF DEATH Month <u>10</u> Day <u>26</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-30-1922</u>
9. AGE (In years last birthday) <u>37</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	11. IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ACCOUNT EXECUTIVE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TELEVISION</u>	
11. BIRTHPLACE (State or foreign country) <u>Niagara Falls, N. Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John J. Sticht</u>		14. MOTHER'S MAIDEN NAME <u>Leola Doyle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>		16. SOCIAL SECURITY NO <u>094-16-4910</u>	
17. ADDRESS <u>Clifford H. Taylor 8505 Howell Rd., Beth., Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asystole</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Coronary arteriosclerosis</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 25</u> , 19 <u>59</u> , to <u>Oct 26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct 30</u> , 19 <u>59</u> , and that death occurred at <u>4 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William Henry Kelly</u>		ADDRESS (Street, city or town, state) <u>9902 Central Rd Bethesda Md</u>	
PHYSICIAN'S NAME (Type) <u>William Henry Kelly</u>		DATE SIGNED <u>Oct 30 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/29/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		24a. REC'D BY REGISTRAR <u>Oct 30 1959</u>	
ADDRESS <u>Bethesda, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>William H. Kelly</u>	

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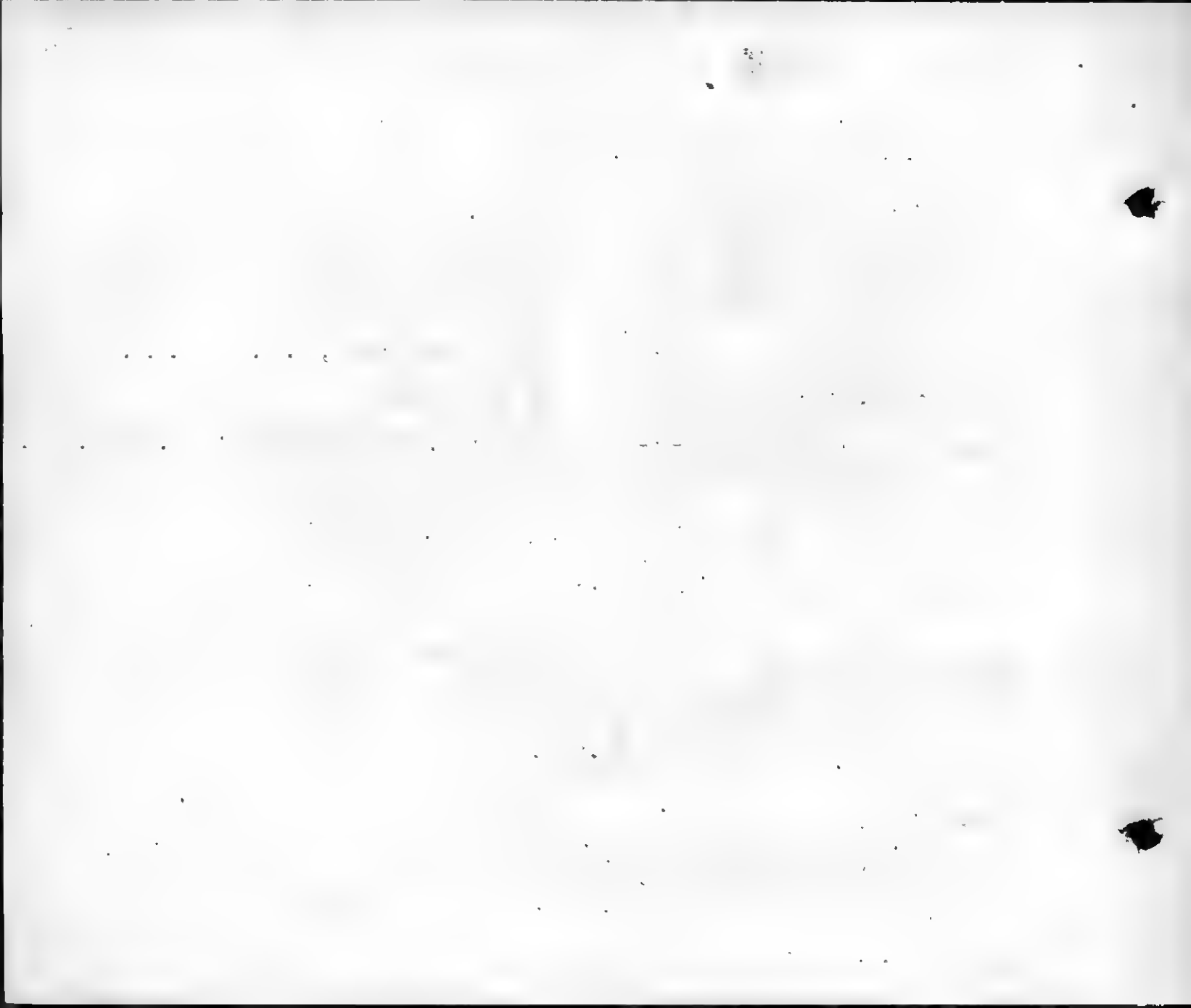
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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



11673

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>015</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Calverton</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Calverton</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS <u>27 Maryland Ave</u>		
3. NAME OF DECEASED (Type or print) First <u>Roale</u> Middle <u>Elizabeth</u> Last <u>Talbott</u>			4. DATE OF DEATH Month <u>Oct</u> Day <u>15</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jul-26-1896</u>	9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>11</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Black</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>John W. Stephens</u>		
14. MOTHER'S MAIDEN NAME <u>Sarah E. Ault</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT <u>309 Frederick Ave</u> <u>Roy L. Talbott, Gaithersburg, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1950</u> to <u>Mar 15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Apr 17</u> , 19 <u>59</u> , and that death occurred at <u>6:15 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8 Russell Ave Gaithersburg Md</u> DATE SIGNED <u>10-16-59</u>					
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.			PHYSICIAN'S NAME (Type) <u>FRANK J. Broschert</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-17-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner, Gaithersburg, Md.</u>			24a. REC'D BY REGISTRAR <u>DATE OCT 19 59</u>		24b. REGISTRAR'S SIGNATURE <u>William J. King</u>

TO HOSPITALS: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



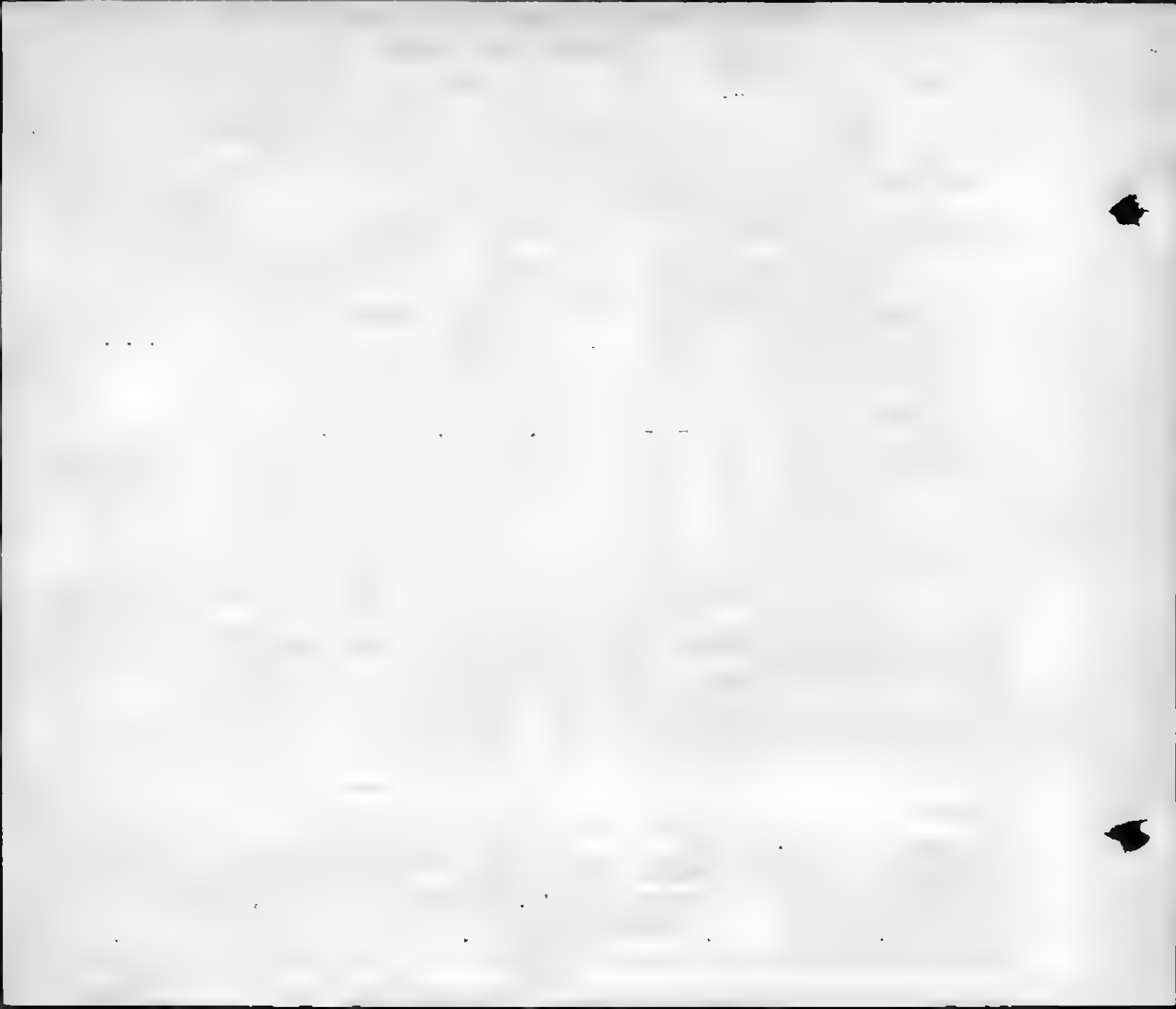
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2417 SEMINARY ROAD</b>		d. STREET ADDRESS <b>2417 SEMINARY ROAD</b>	
3. NAME OF DECEASED (Type or print) First <b>Carl</b> Middle <b>Tamorra</b> Last <b>Tamorra</b>		4. DATE OF DEATH Month <b>October</b> Day <b>28</b> Year <b>1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/6/07</b>
9. AGE (In years last birthday) <b>52</b> yrs.		10. IF UNDER 1 YEAR: Months <b>28</b> Days <b>28</b> Hours <b>28</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>	11. BIRTHPLACE (State or foreign country) <b>Italy</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>IGNATIUS TAMORRIA</b>	
14. MOTHER'S MAIDEN NAME <b>AGATE</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>WW #2</b>	
16. SOCIAL SECURITY NO <b>577-05-7260</b>		17. INFORMANT <b>Mrs. Lena J. Tamorra, 2417 Seminary Road Silver Spring, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Artery Sclerosis</b> DUE TO (c) <b>5 yrs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a)			
19. WAS AUTOPSY PERFORMED? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>a. m.</b> <b>19</b> Month <b>10</b> Day <b>28</b> Year <b>1959</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>27 Oct 1959</b> , to <b>28 Oct 1959</b> , that I last saw the deceased alive on <b>28 Oct 1959</b> , and that death occurred at <b>1:45 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Merton L. White</b>		ADDRESS (Street, city or town, state) <b>11134 Georgia Ave, Silver Spring, Md 20904</b>	
PHYSICIAN'S NAME (Type) <b>MERTON L. WHITE</b>		DATE SIGNED <b>11/3/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>10/30/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NAT'L. CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>ARLINGTON, VIRGINIA</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. Zuka</b>		24a. REC'D BY REGISTRAR <b>SILVER SPRING, MD.</b> <b>DATE OCT 30 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





11677

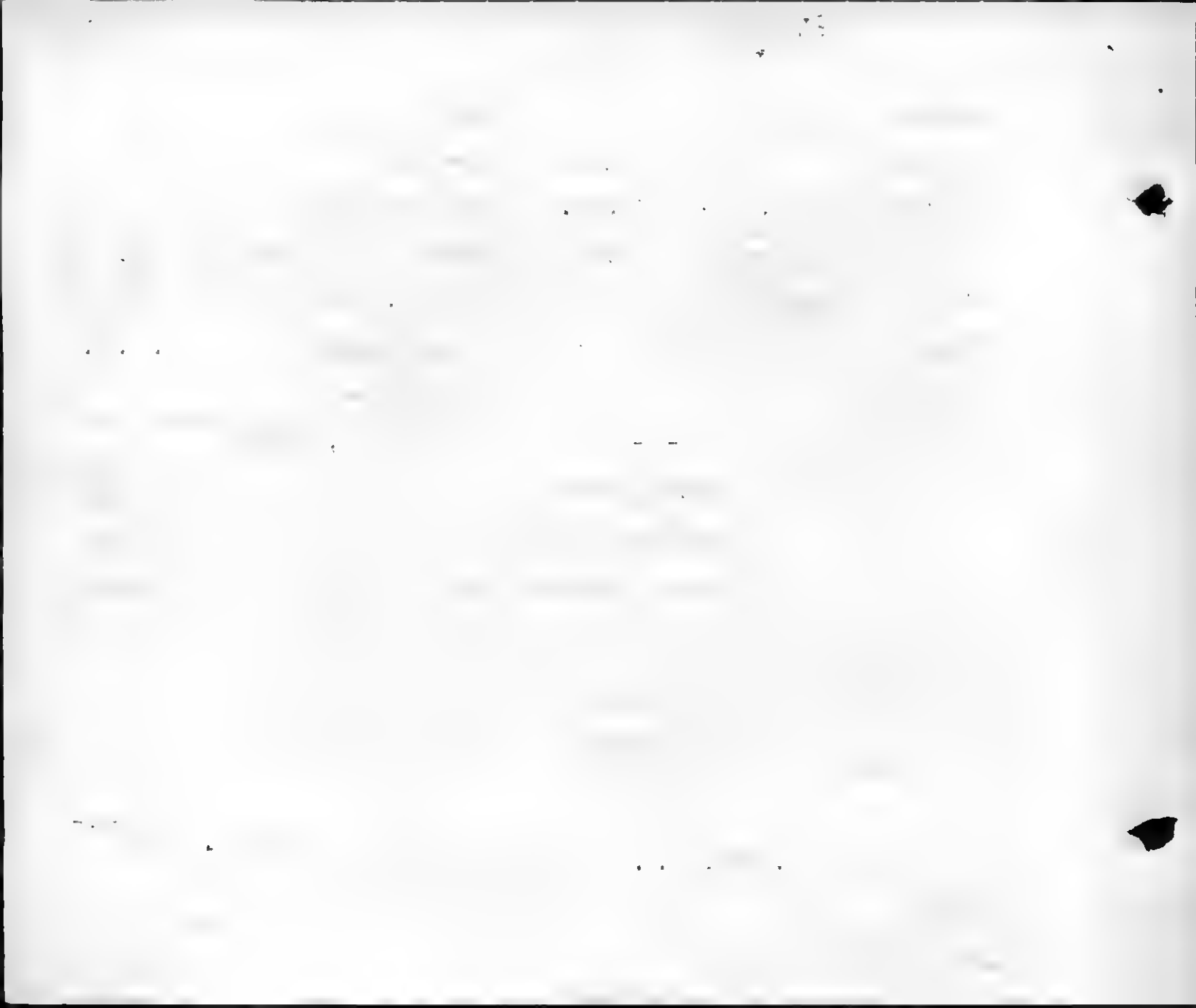
CERTIFICATE OF DEATH

11655

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>30 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>North Carolina</b> b. COUNTY <b>Wake</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kannapolis</b> d. STREET ADDRESS <b>918 Taylor Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Joe</b> Middle <b>Elmore</b> Last <b>Thomas</b>		4. DATE OF DEATH Month <b>October</b> Day <b>31</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 30, 1933</b> 9. AGE (In years last birthday) <b>25</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public School</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Clyde Thomas</b>		14. MOTHER'S MAIDEN NAME <b>Bess Elmore</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>241-44-1971</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal Insufficiency</b> <b>288x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Gouty Nephropathy</b> DUE TO (c) <b>Chronic Tophaceous Gout</b>		INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>years</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 1, 19 59</b> to <b>October 31, 19 59</b> , that I last saw the deceased alive on <b>October 31, 19 59</b> , and that death occurred at <b>4:30 A.</b> M., from the causes and on the date stated above.			
22a. SIGNATURE <b>Martin J. Wohl</b>		22b. DATE THEREOF <b>11/3/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Carolina Memorial Cemetery, Kannapolis, Carolina</b>		22d. LOCATION (City, town, or county) (State) <b>Bethesda 14, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Humphrey</b>		24a. REC'D BY REGISTRAR <b>Arthur S. Kraus</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		DATE NOV 4 '59	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

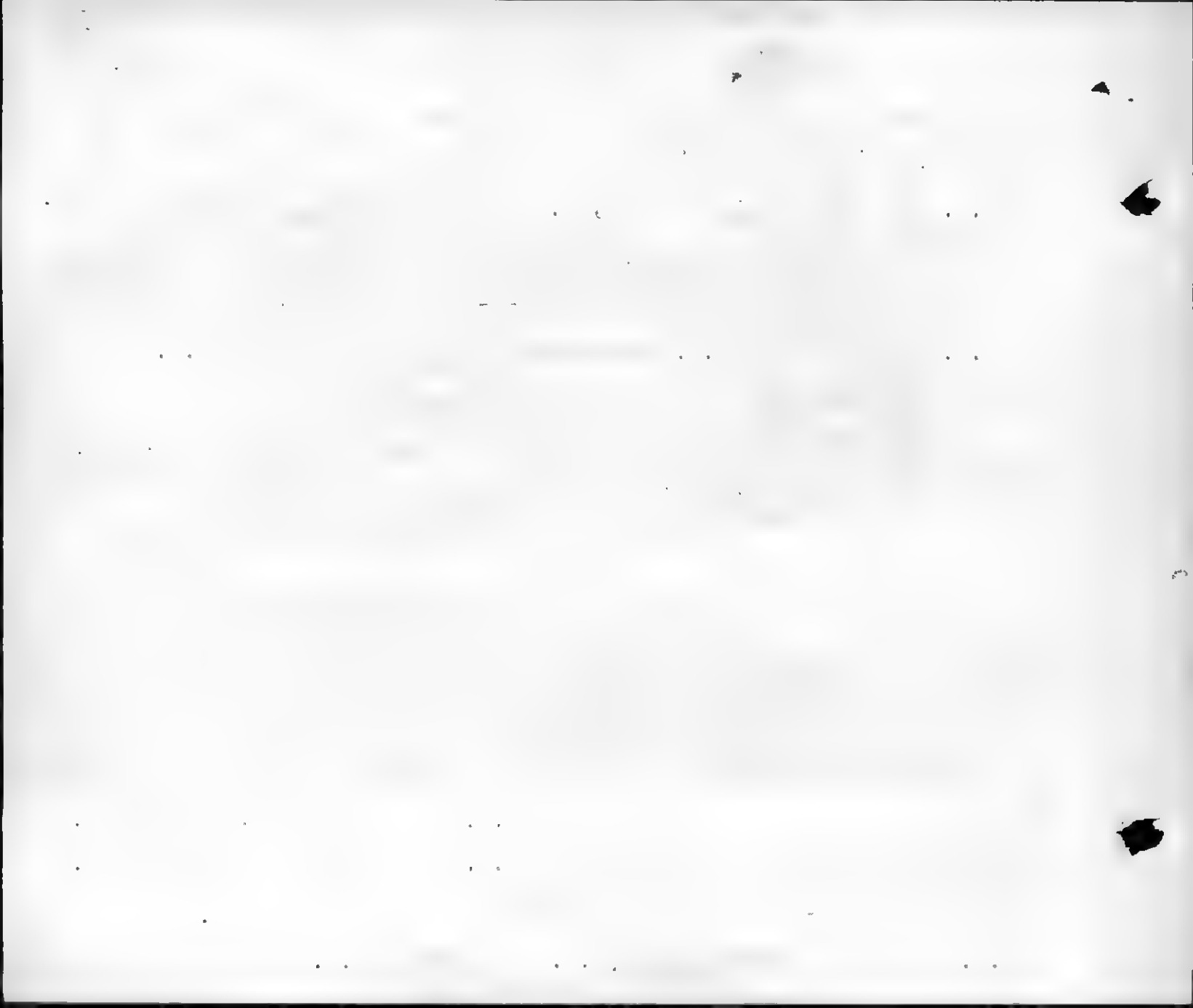


11678

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN TB <b>2 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>2.1</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> d. STREET ADDRESS <b>147 Prince George Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Joseph Armond THOMPSON</b>				4. DATE OF DEATH Month Day Year <b>October 19 1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-9-21</b>	
9. AGE (In years last birthday) <b>38</b>		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) <b>Florida</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Navy</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>			
13. FATHER'S NAME <b>William THOMPSON</b>				14. MOTHER'S MAIDEN NAME <b>Emily ERD</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>WW II</b>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>153.8</b> DUE TO <b>Cardiac Respiratory Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Metastatic Carcinoma to Brain</b> DUE TO <b>Primary Carcinoma of Colon</b> (c) <b>Primary Carcinoma of Colon</b>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Annapolis</b>				20g. (County) <b>Prince George's</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>17 October 1959</b> to <b>19 October 1959</b> that I last saw the deceased alive on <b>19 October 1959</b> and that death occurred at <b>6:38 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda Md.</b> DATE SIGNED <b>10-20-59</b> ACTUAL SIGNATURE <b>William P. Baker</b> M.D. <b>U.S. Naval Hospital, Bethesda Md.</b> PHYSICIAN'S NAME (Type) <b>William P. BAKER LT MC USN U.S. Naval Hospital, Bethesda Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-23-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers</b>				ADDRESS <b>1400 Chapin St. N.W. Washington, D.C.</b>		24a. REC'D BY REGISTRAR <b>Oct 23 1959</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hargis</b>							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

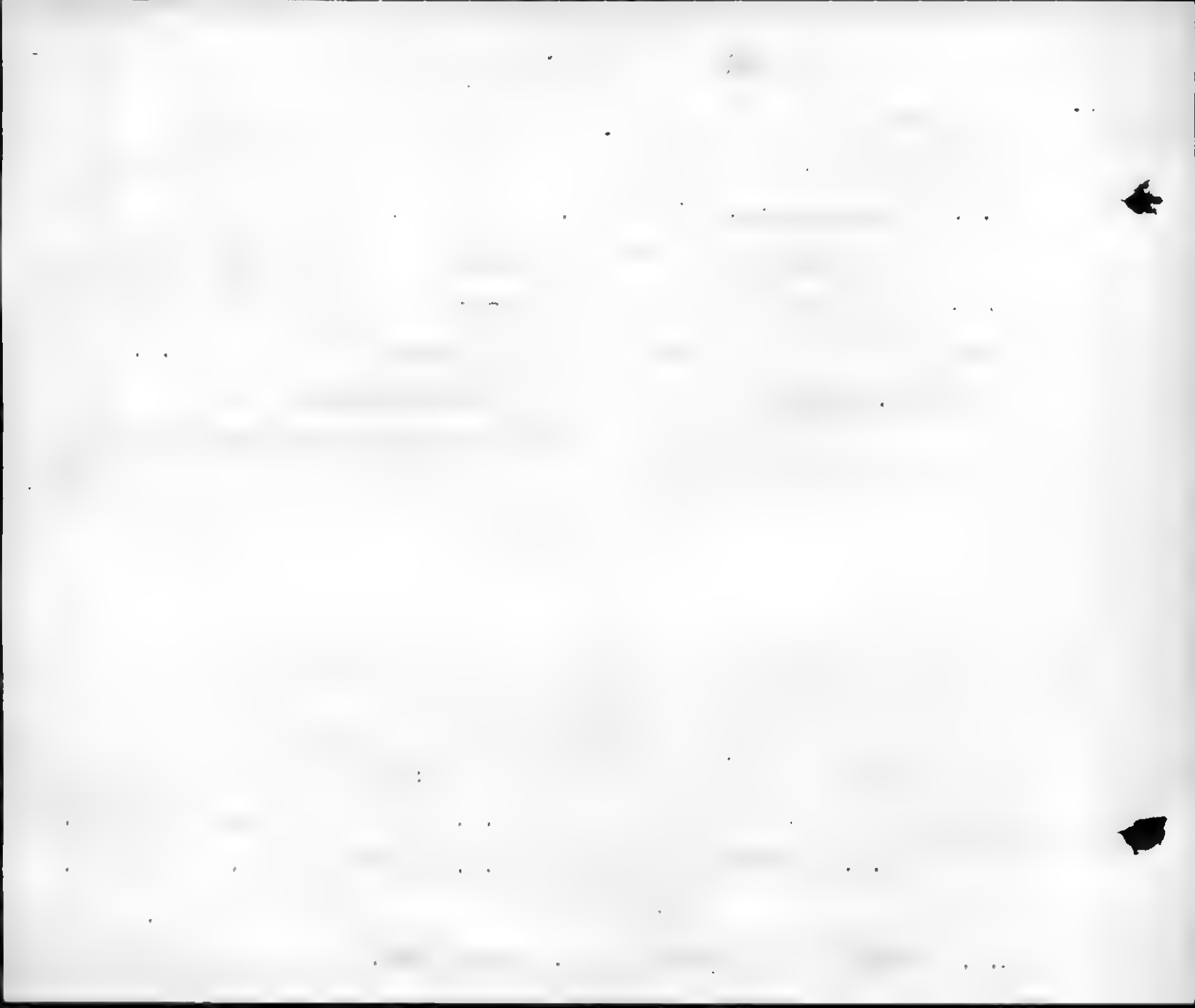
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11679

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>4 1/2 hours</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>				2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Virginia</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Midway Island</b> d. STREET ADDRESS <b>62 Henderson Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Baby Boy TRYTHALL</b>				4. DATE OF DEATH Month Day Year <b>October 3 1959</b>			
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>10-2-59</b>	9 AGE (In years lost birthday) yrs <b>1</b>	IF UNDER 1 YEAR Months Days <b>1</b>	IF UNDER 24 HRS Hours Min. <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11 BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13 FATHER'S NAME <b>Donald L. TRYTHALL</b>				14. MOTHER'S MAIDEN NAME <b>Rita M DEPPENS</b>			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT Address <b>(Father) Donald L Trythall Same as #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Trachea-esophageal Fistula</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>and Prematurity</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>40 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d INJURY OCCURRED While of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3 October 1959</b> to <b>3 October 1959</b> that I last saw the deceased alive on <b>3 October 1959</b> and that death occurred at <b>11:55 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda Md. 10-5-59</b>							
ACTUAL SIGNATURE <b>H. L. Walton</b>		M.D. <b>U.S. Naval Hospital, Bethesda Md.</b>					
PHYSICIAN'S NAME (Type) <b>H. L. WALTON LT MC USN</b>		<b>U.S. Naval Hospital, Bethesda Md.</b>					
22a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-8-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Laureldale</b>		22d. LOCATION (City, town, or county) (State) <b>Laureldale Penn.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumphrey</b> ADDRESS <b>755P Wisconsin Ave. Bethesda Md.</b>				24a. REC'D BY REGISTRAR <b>7 '59</b>		24b REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



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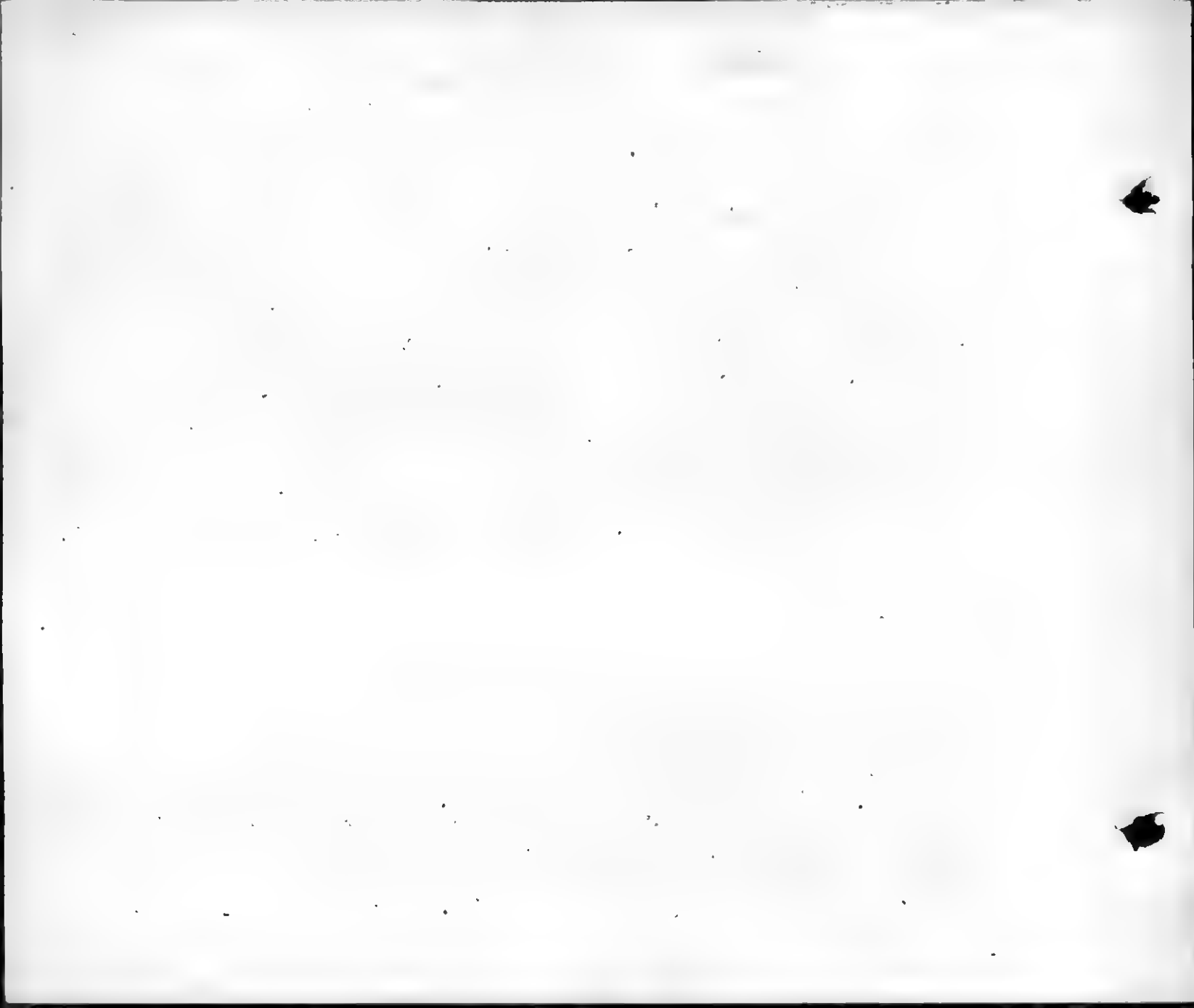
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. LENGTH OF STAY IN 1b <b>18 YRS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4612 CHELTENHAM DRIVE</b>				d. STREET ADDRESS <b>4612 CHELTENHAM DRIVE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LOUIS</b> Middle <b>JOSEPH</b> Last <b>URCIOLO</b>				4. DATE OF DEATH Month <b>10</b> Day <b>31</b> Year <b>1959</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 25, 1913</b>	9. AGE (In years last birthday) <b>46</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PUBLIC ACCOUNTANT</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>WASHINGTON, D.C.</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>		
13. FATHER'S NAME <b>ANGELO URICIOLO</b>				14. MOTHER'S MAIDEN NAME <b>ANTONETTE FISCHERIA</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO <b>WWTI 577-10-2099</b>		17. INFORMANT <b>MARY P. URICIOLO (WIFE)</b> Address <b>4612 CHELTENHAM DR., BETHESDA.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>443 X ACUTE PULMONARY EDEMA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PEPTIC ULCER</b>						INTERVAL BETWEEN ONSET AND DEATH <b>20 YEARS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>AUG.</b> , 19 <b>46</b> , to <b>OCT 31</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>OCT 27</b> , 19 <b>59</b> , and that death occurred at <b>6:15 A.M.</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>Robert h. Coale</b> M.D. <b>4630 Montgomery Ave., Bethesda Md</b> DATE SIGNED <b>10/31/59</b> PHYSICIAN'S NAME (Type) <b>ROBERT N. COALE MD</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/3/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Fort Meade Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank Geiers Sons Co</b> ADDRESS <b>3605-14th N.W.</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 2 '59</b>		24b. REGISTRAR'S SIGNATURE <b>C. L. S. Kraus</b>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





11681

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE _____ b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville, Md.</u>		c. LENGTH OF STAY IN 1b _____	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Pennington Garden Sanitarium Wash., D.C.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>First Middle Last</u> <u>VACARO ROSA M. VACRONI</u>		4. DATE OF DEATH Month <u>OCT</u> Day <u>24</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR 25-1899</u>
9. AGE (In years last birthday) <u>69</u> yrs		10. IF UNDER 1 YEAR: Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OWNER OF RESTAURANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ITALY</u>	
11. BIRTHPLACE (State or foreign country) <u>US</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>LORENZO CAPONE</u>		14. MOTHER'S MAIDEN NAME <u>CATERINA LE DONNE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>Luigi A. VACRONI</u> Address <u>7230 Westview Wyndhurst, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Infarct</u> <u>334X</u> DUE TO <u>Cerebrovascular Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>Generalized Arteriosclerosis</u> (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>FRACTURE RT. Hip - old</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month _____ Day _____ Year _____ Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>12:40</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edwin P. Parker</u> M.D.		ADDRESS (Street, city or town, state) <u>2015 18th St NW, Wash. DC</u>	
PHYSICIAN'S NAME (Type) <u>EDWIN P. PARKER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-27-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fox Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Bladensburg Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leaf Funeral Home</u> ADDRESS <u>4812 Galois Rd DC</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 27 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Carlton J. King</u>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11528

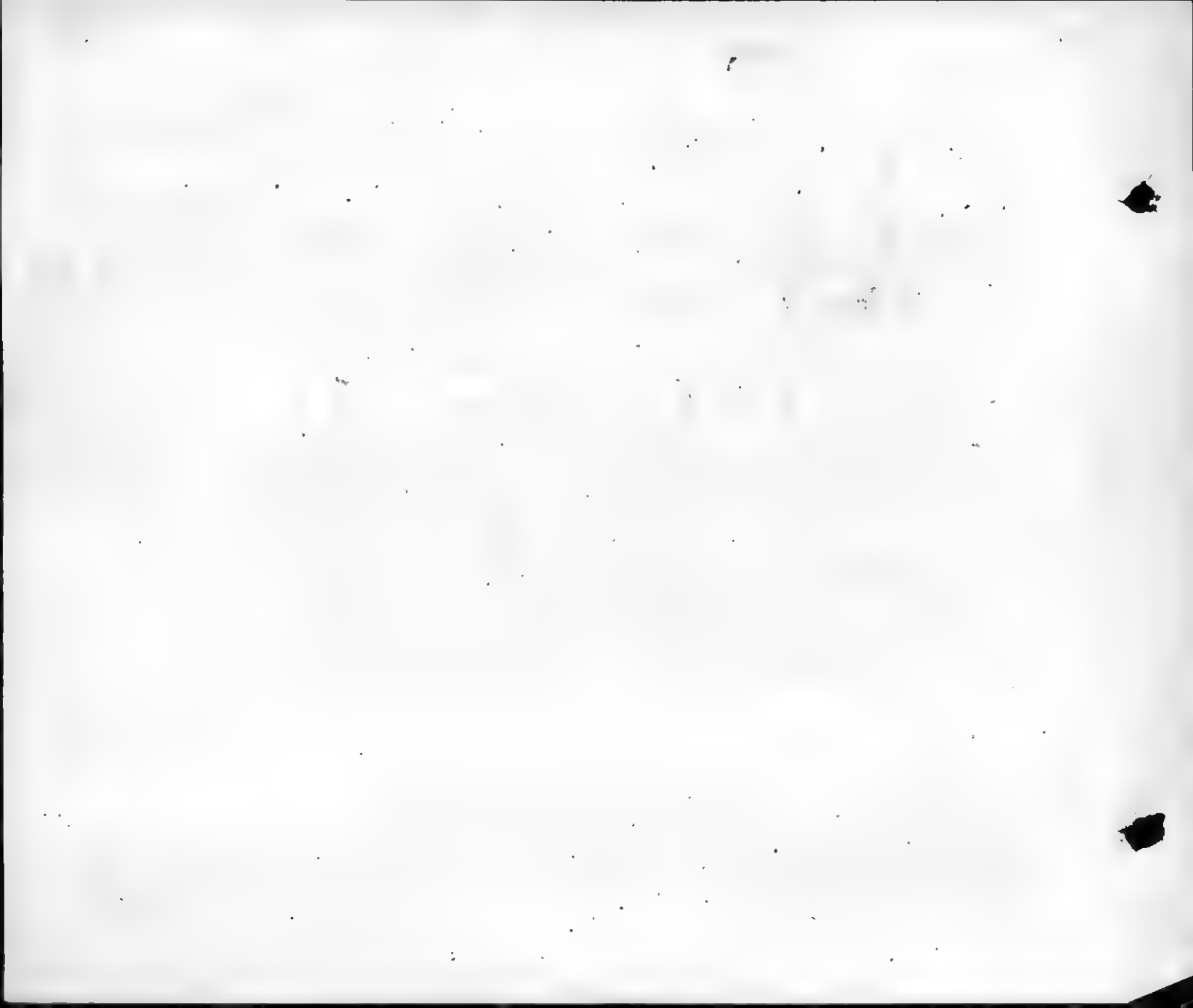
## CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakewood Park / hr-20 min</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>(V.M.)</u> Last <u>Valltos</u>		4. DATE OF DEATH Month <u>10</u> Day <u>1</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-3-94</u>
9. AGE (In years last birthday) <u>63</u> yrs		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>3</u> Hours <u>3</u> Min <u>3</u>	11. IF UNDER 24 HRS Hours <u>3</u> Min <u>3</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Greece</u>
12. CITIZEN OF WHAT COUNTRY? <u>America</u>		13. FATHER'S NAME <u>Steven Kabetain</u>	
14. MOTHER'S MAIDEN NAME <u>?</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO <u>—</u>		INFORMANT <u>Hospital Records</u> Address <u>—</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO (b) <u>Acute Coronary thrombosis</u> DUE TO (c) <u>Diabetes mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9/30</u> , 19 <u>59</u> , to <u>10/1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10/1</u> , 19 <u>59</u> , and that death occurred at <u>12:30</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bennet A. Porter, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>9301 Colesville Rd, Silver Spring, Md.</u> DATE SIGNED <u>Oct. 1, 59</u>	
PHYSICIAN'S NAME (Type) <u>Bennet A. Porter, Jr., M.D.</u>		<u>9301 Colesville Rd, Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Oct 3, 59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Blair Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Blair Hill</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.C. Thompson &amp; Son</u>		24a. REC'D BY REGISTRAR <u>5732</u>	24b. REGISTRAR'S SIGNATURE <u>—</u>
DATE <u>OCT 5 2 59</u>		DATE <u>OCT 5 2 59</u>	



11682

## CERTIFICATE OF DEATH

Reg. Dist. No.

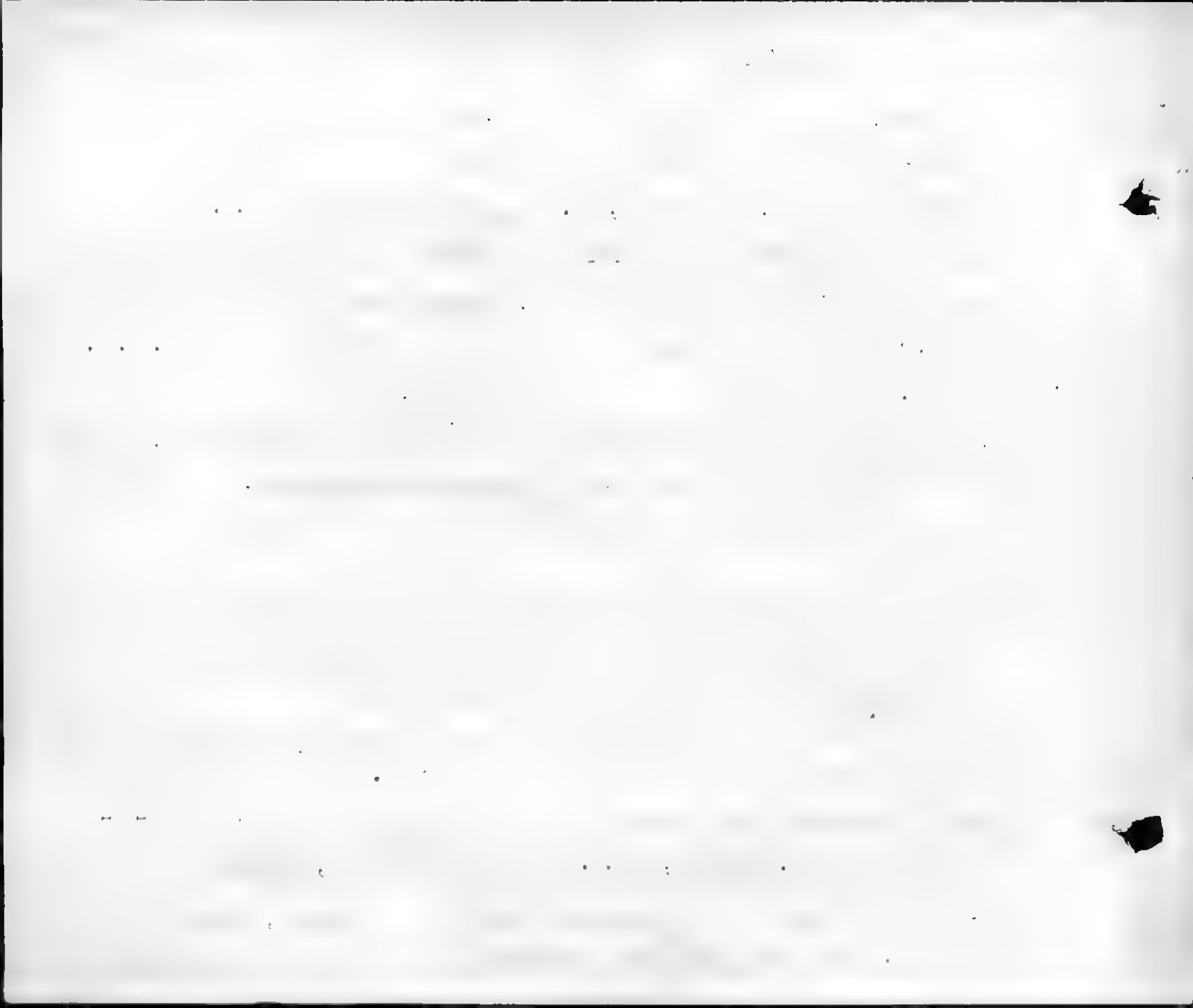
11661

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>28 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Ohio</b> b. COUNTY <b>Warren</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>7. x</b> d. STREET ADDRESS <b>427 Central Parkway, S.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ALVIN</b> Middle <b>CARL</b> Last <b>VICK</b>		4. DATE OF DEATH Month <b>October</b> Day <b>31,</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>21 February 1900</b>
9. AGE (In years last birthday) <b>59</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>	
11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Henry C. Vick</b>		14. MOTHER'S MAIDEN NAME <b>Ida Lebowsky</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>unavailable</b>	
INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adrenal Cortical Carcinoma with Metastasis</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>3 Years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY—Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 3, 1959</b> to <b>October 31, 1959</b> , that I last saw the deceased alive on <b>October 31, 1959</b> , and that death occurred at <b>9:24 a.m.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Howard S. Schwartz</b> PHYSICIAN'S NAME (Type) <b>HOWARD S. SCHWARTZ, M.D.</b>		ADDRESS (Street, city or town, state) <b>The Clinical Center National Institutes of Health Bethesda 14, Maryland</b> DATE SIGNED <b>10-31-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit 11/4/59</b>		22b. DATE THEREOF <b>11/4/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Crown Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Vienna, Ohio</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 4 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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X

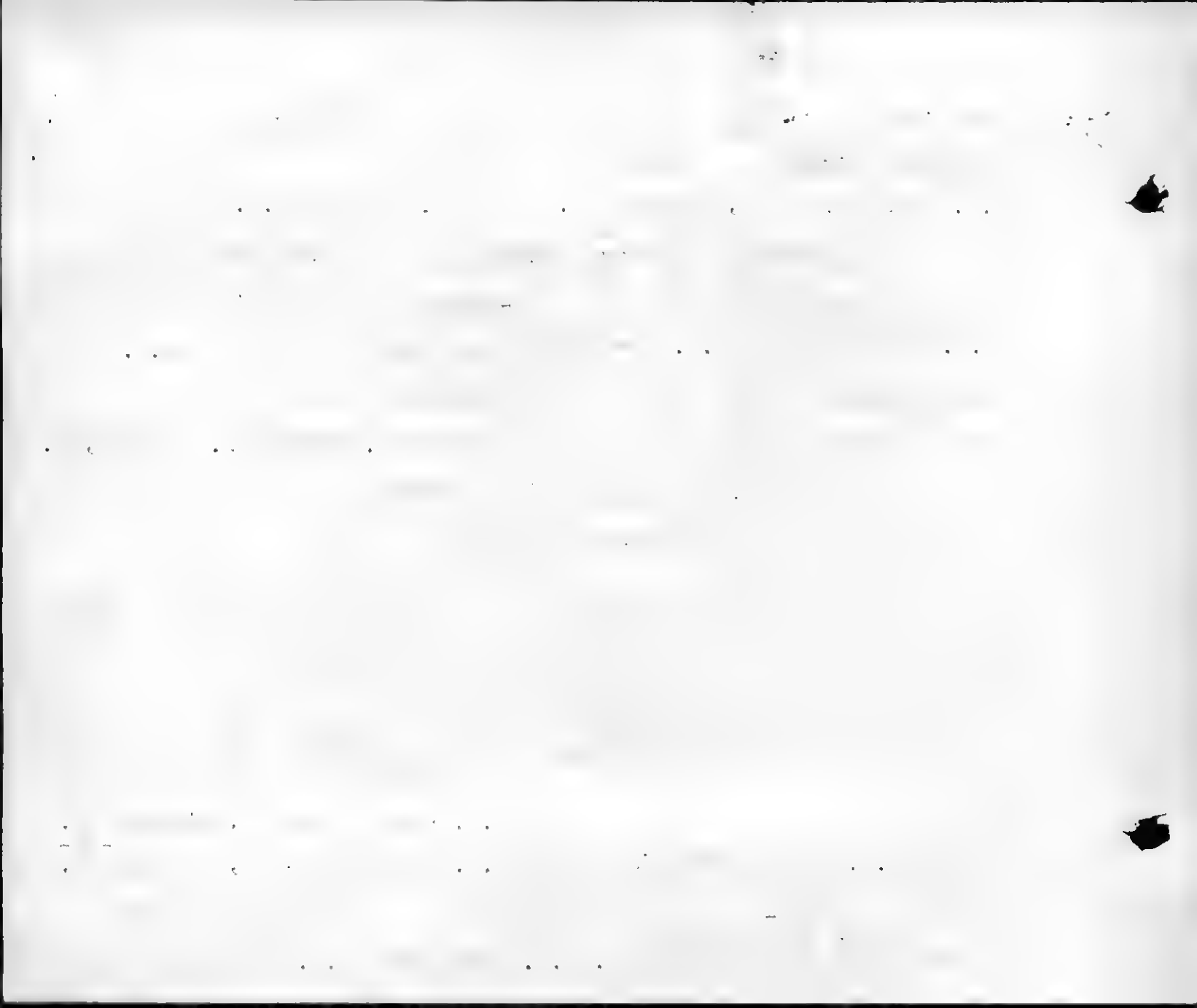
11683

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11662  
Reg. Dist. No. 215

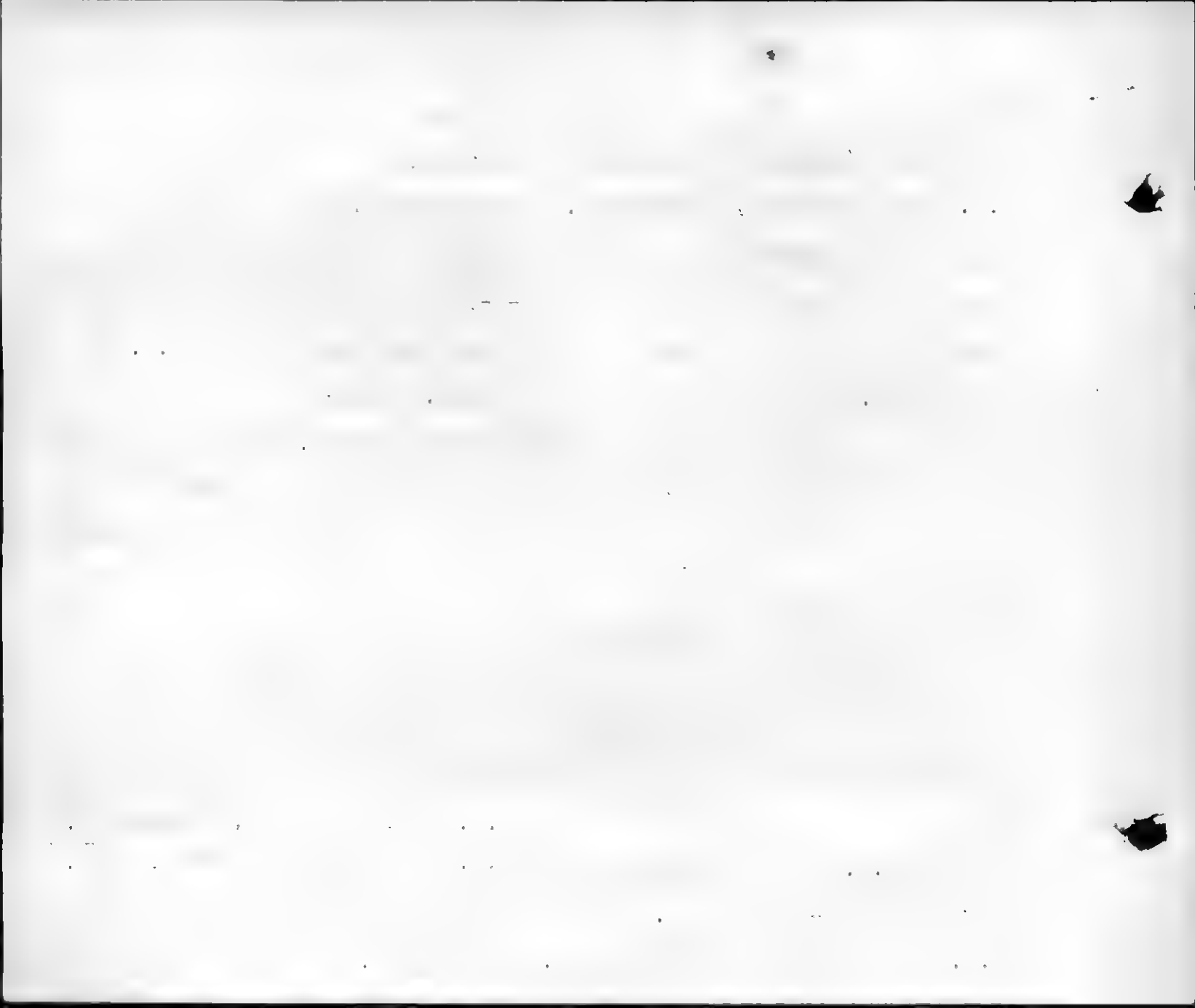
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>11 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>District of Columbia</b>		b. COUNTY <b>Washington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		d. STREET ADDRESS <b>1605 "D" Street N.E.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>		3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Frank</b> Last <b>WAGNER</b>		4. DATE OF DEATH Month <b>October</b> Day <b>9</b> Year <b>19 59</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-19-98</b>		9. AGE (In years last birthday) <b>61</b> yrs		10. IF UNDER 1 YEAR Months <b>61</b> Days <b>1</b> Hours <b>1</b> Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Joseph Wagner</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO <b>Informant (Son) Joseph F. Wagner Jr. Clinton, Md.</b>		17. ADDRESS <b>Informant (Son) Joseph F. Wagner Jr. Clinton, Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cornary artery disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour <b>9</b> a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>28 Sept</b> , 19 <b>59</b> , to <b>9 October</b> , 19 <b>59</b> , and that death occurred at <b>9:30 PM</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda Md.</b>		DATE SIGNED <b>10-10-59</b>		ACTUAL SIGNATURE <b>Bruce H. Rice</b>		M.D. <b>U.S. Naval Hospital, Bethesda Md.</b>		PHYSICIAN'S NAME (Type) <b>B.H. RICE LT MC USN</b>		U.S. Naval Hospital, Bethesda Md.		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-14-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LEE 4th and Massachusetts Ave. N.W. Washington D.C.</b>		24a. REC'D BY REGISTRAR <b>16 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		25. TO HOSPITAL may be released to the hospital or attending physician.		26. TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.		27. VS A15 (4) 15M 9/58		28. 1		29. 2		30. 3					





VS A15 (4)  
ISM 9/SB

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>10 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince George's</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <b>219 Fig Street</b>											
3. NAME OF DECEASED (Type or print) <b>Richard Leon WALCOTT</b>		First <b>Richard</b>		Middle <b>Leon</b>		Last <b>WALCOTT</b>		4. DATE OF DEATH Month <b>October</b>		Day <b>15</b>		Year <b>1959</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-2-50</b>		9. AGE (In years last birthday) yrs <b>9</b>		IF UNDER 1 YEAR Months <b></b>		IF UNDER 24 HRS Days <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>									
13. FATHER'S NAME <b>William T. WALCOTT</b>		14. MOTHER'S MAIDEN NAME <b>Ida M. MILLER</b>													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>(Father) William T. Walcott Same as #2</b>		Address <b></b>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congenital heart disease (Tetralogy of Fallot)</b> <b>754.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>with atrial septal defect</b> post surgical correction DUE TO (c) <b>status</b>														INTERVAL BETWEEN ONSET AND DEATH <b></b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>														19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b></b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b></b>		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>		20f. (City or town) (County) (State) <b></b>					
21. I certify that I attended the deceased from <b>5 October, 1959</b> to <b>15 October, 1959</b> that I last saw the deceased alive on <b>15 October, 1959</b> , and that death occurred at <b>1:36 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda Md.</b> DATE SIGNED <b>10-16-59</b>															
ACTUAL SIGNATURE <b>James E. Mc Clenathan</b>		M.D. <b>U.S. Naval Hospital, Bethesda Md.</b>													
PHYSICIAN'S NAME (Type) <b>J.E. MC CLENATHEN CDR MC USN</b>		U.S. Naval Hospital, Bethesda Md.													
22b. BURIAL, CREMAT. OR REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-18-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Pauls Lutheran Church</b>		22d. LOCATION (City, town, or county) (State) <b>Stover Missouri</b>									
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumphrey</b>		ADDRESS <b>7557 Wisconsin Ave.</b>		24a. REC'D BY REGISTRAR <b>1959</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Thomas</b>									



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

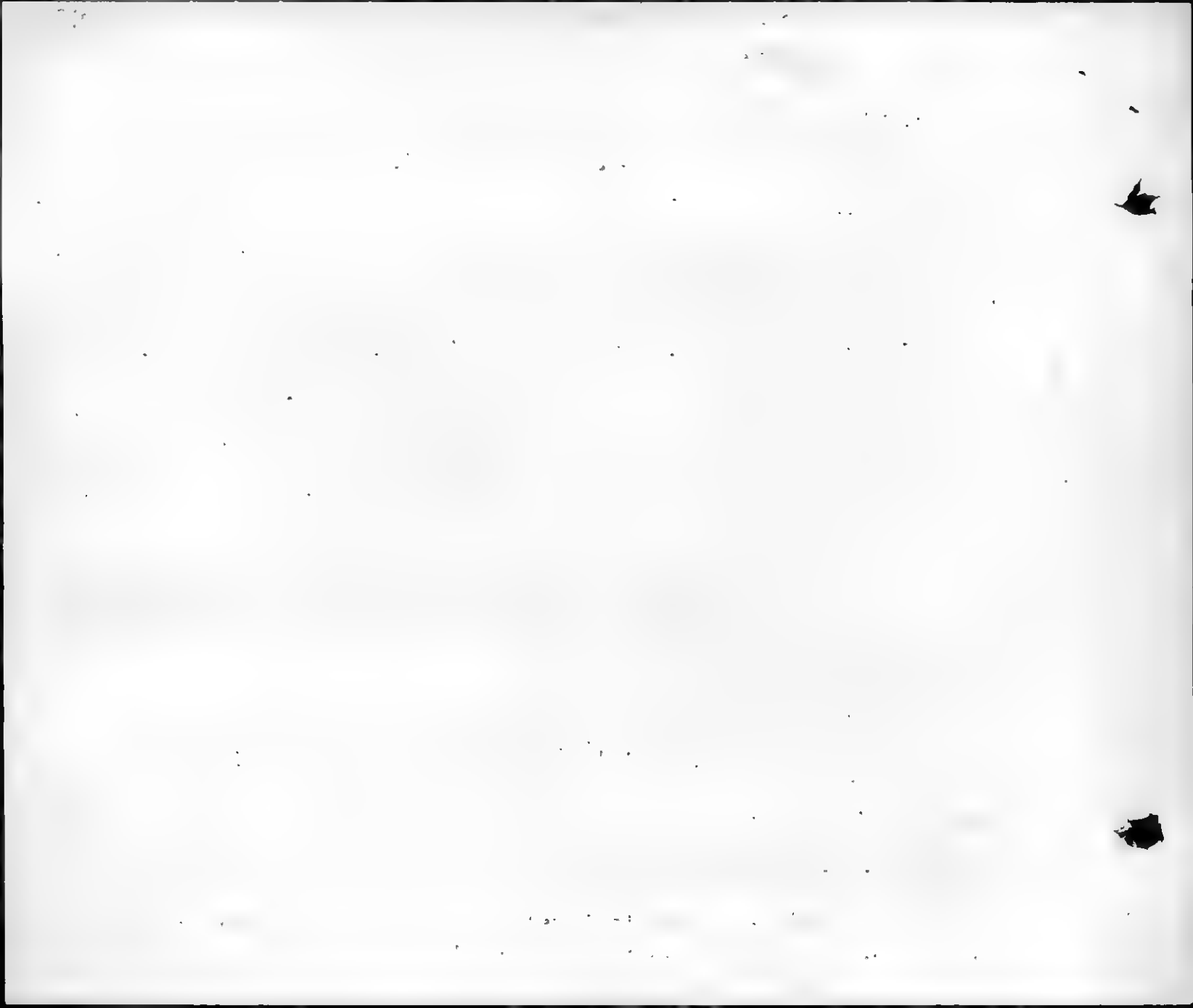
11685

## CERTIFICATE OF DEATH

11664

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Maryland</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Maryland</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>4621-N Chiles Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Horatio</u> Middle <u>Wales</u> Last <u>Wales</u>				4. DATE OF DEATH Month <u>10</u> Day <u>17</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-12-94</u>	9. AGE (In years last birthday) <u>65</u> yrs	IF UNDER 1 YEAR Months <u>8</u> Days <u>3</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chemist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S Gov't</u>		11. BIRTHPLACE (State or foreign country) <u>Western Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Horatio Wales</u>				14. MOTHER'S MAIDEN NAME <u>Emma Spear</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT <u>Mrs. Merle M Wales</u>		Address <u>Bethesda Md 4621-N Chiles Lane</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary embolism, bilateral</u> <u>465X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>5:30</u> <u>Oct 17</u> <u>1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>14 Oct</u> , 19 <u>59</u> , to <u>10/17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10/16</u> , 19 <u>59</u> , and that death occurred at <u>5:25 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H P Dorman</u>				ADDRESS (Street, city or town, state) <u>M.D. 1302 18th St NW</u>		DATE SIGNED <u>10/17/59</u>	
PHYSICIAN'S NAME (Type) <u>H. P. Dorman</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/19/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>OCT 20 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>C. L. S. Frank</u>	



11686

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>215 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>Edward</b> Last <b>Walsh</b>				4. DATE OF DEATH Month <b>October</b> Day <b>10</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 23, 1905</b>	
9. AGE (In years last birthday) <b>54</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Penitentiary</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas M. Walsh</b>				14. MOTHER'S MAIDEN NAME <b>Ellen Ruane</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>205-10-5636</b>		INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Empyema, right lung and pleura</b> DUE TO (b) <b>Lymphosarcoma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>March 9</b> , 19 <b>59</b> , to <b>October 10</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>October 10</b> , 19 <b>59</b> , and that death occurred at <b>6:50a</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>10-10-59</b> ACTUAL SIGNATURE <b>Jerry S. Trier</b> M.D. <b>The Clinical Center</b> PHYSICIAN'S NAME (Type) <b>Jerry S. Trier, M.D.</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>							
22a. BURIAL CREMATION, RITUAL (Specify) <b>Burial-transit</b>		22b. DATE THEREOF <b>10-11-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cathedral Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Scranton, Penna.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b> <b>Bethesda, Md.</b> <i>Robert A. Pumphrey</i>				24a. REC'D BY REGISTRAR DATE <b>OCT 14 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

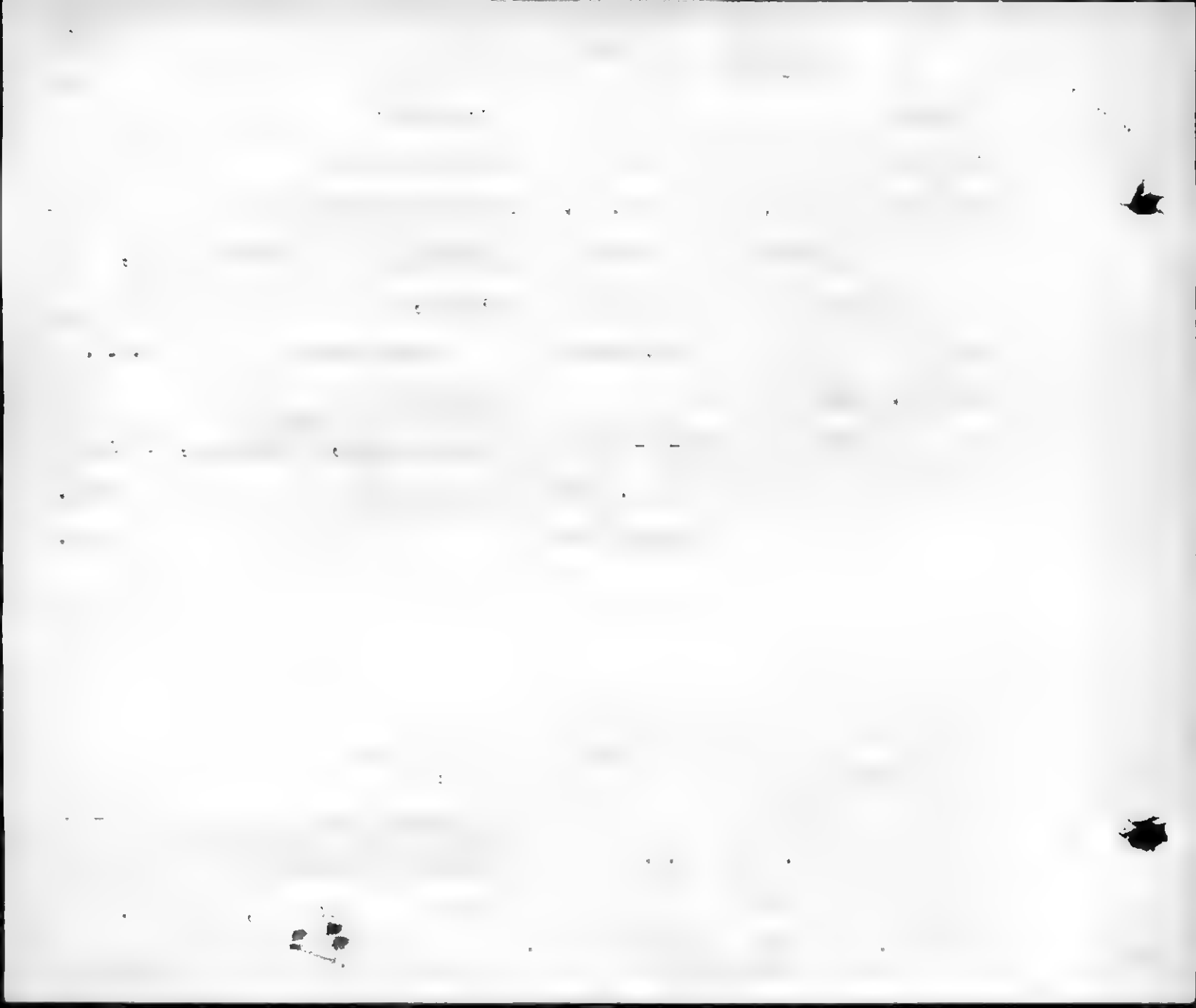
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

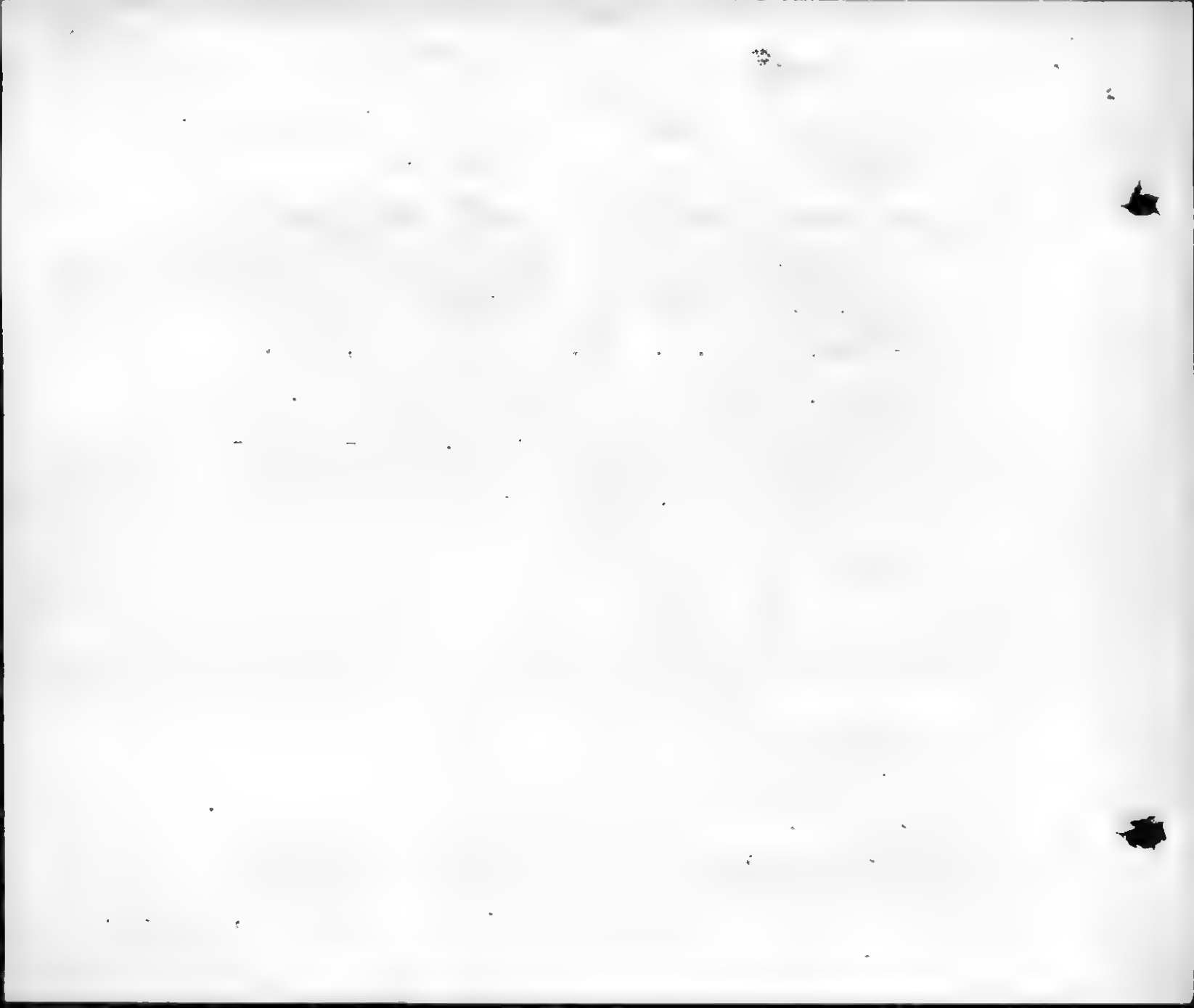
11666

11687

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Res. dence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>10014 Sinnott Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GLADYS</b> Middle <b>MARY</b> Last <b>WEISS</b>		4. DATE OF DEATH Month <b>October</b> Day <b>7</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/5/1898</b>
9. AGE (In years last birthday) <b>61</b> yrs.		10. IF UNDER 1 YEAR Months <b>61</b> Days <b>61</b> Hours <b>61</b> Min.	11. IF UNDER 24 HRS Months <b>61</b> Days <b>61</b> Hours <b>61</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk-typist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Govt.</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Charles C. Cook</b>		14. MOTHER'S MAIDEN NAME <b>Josephine L. Hanfmann</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Yes</b>	
17. INFORMANT <b>George B. Weiss-Husband-same as 2d</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>INSTANT</b> <b>4 YRS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>SEPT</b> , 19 <b>55</b> , to <b>OCT</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Oct 5th</b> , 19 <b>59</b> , and that death occurred at <b>5 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Leo E Donovan</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>10/1/59</b>	
PHYSICIAN'S NAME (Type) <b>Leo E Donovan</b>		<b>Bethesda 14 MO</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/12/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		24. REC'D BY REGISTRAR <b>Oct 13 59</b>	
ADDRESS <b>Bethesda, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur J. Thomas</b>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11667

11688

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Montgomery</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Gaithersburg</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>P.O. Box 349</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <div style="display: flex; justify-content: space-between;"> <span>First <u>Beulah</u></span> <span>Middle <u>V.</u></span> <span>Last <u>Welch</u></span> </div>				<b>4. DATE OF DEATH</b> <div style="display: flex; justify-content: space-between;"> <span>Month <u>10</u></span> <span>Day <u>28</u></span> <span>Year <u>19 59</u></span> </div>			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>3/24/04</u>		<b>9. AGE</b> (In years last birthday) <u>55</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>			
<b>11. IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Va.</u>			
<b>11. BIRTHPLACE</b> (State or foreign country) <u>U. S. A</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A</u>					
<b>13. FATHER'S NAME</b> <u>E. Hicks</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Bessie Musser</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO</b> <u>  </u>		<b>17. INFORMANT</b> <u>Sam Gale Welch</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiovascular collapse</u> DUE TO <u>Irreversible shock</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 minutes</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Status: Operation procedure - Brought to feet and left hyp</u>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Fell on Kitchen Floor</u>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>6:30</u> <u>PM</u> <u>10-23-59</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u>			
<b>20f. (City or town)</b> <u>Gaithersburg</u>		<b>(County)</b> <u>Montgomery</u>		<b>(State)</b> <u>MD</u>			
<b>21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>							
<b>ACTUAL SIGNATURE</b> <u>Frank J. Borchert</u> <span style="float: right;">M.D.</span>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Borchert</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <u>10-29-59</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>10-31-59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Groseclose Methodist</u>			
<b>22d. LOCATION (City, town, or county)</b> <u>Gaithersburg</u>		<b>(State)</b> <u>MD</u>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Ernest C. Gartner. Gaithersburg. C.</u>				<b>24a. REC'D BY REGISTRAR</b> <u>NOV 2 '59</u>			
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hines</u>				<b>DATE</b> <u>NOV 2 '59</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the State Department of Health, Baltimore, Maryland. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



1

11

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11529

CERTIFICATE OF DEATH

Reg. Dist. No.

11668

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sen &amp; Hosp</u>		d. STREET ADDRESS <u>Apt 36 1401 2nd St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>(None)</u> Last <u>White</u>		4. DATE OF DEATH Month <u>10</u> Day <u>11</u> Year <u>1959</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/15/197</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RN</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Scharf Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Wagner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>Hosp Records</u>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Embolism</u> <u>199.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinomatous - peritoneum</u> (c) <u>Colon</u>		INTERVAL BETWEEN ONSET AND DEATH <u>terminal</u> <u>six mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>59</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9/13</u> , 19 <u>59</u> , to <u>10/11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10/11</u> , 19 <u>59</u> , and that death occurred at <u>2:55</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert A. Hare</u> M.D.		ADDRESS (Street, city or town, state) <u>Takoma Park, Md.</u> DATE SIGNED <u>10/11/59</u>	
PHYSICIAN'S NAME (Type) <u>Robert A. Hare</u> M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>10/13/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, BALTO Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare</u> ADDRESS <u>254 Carroll St NW, WASH D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 13 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Charles A. Hare</u>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Film G249 10-9-59 et

## CERTIFICATE OF DEATH

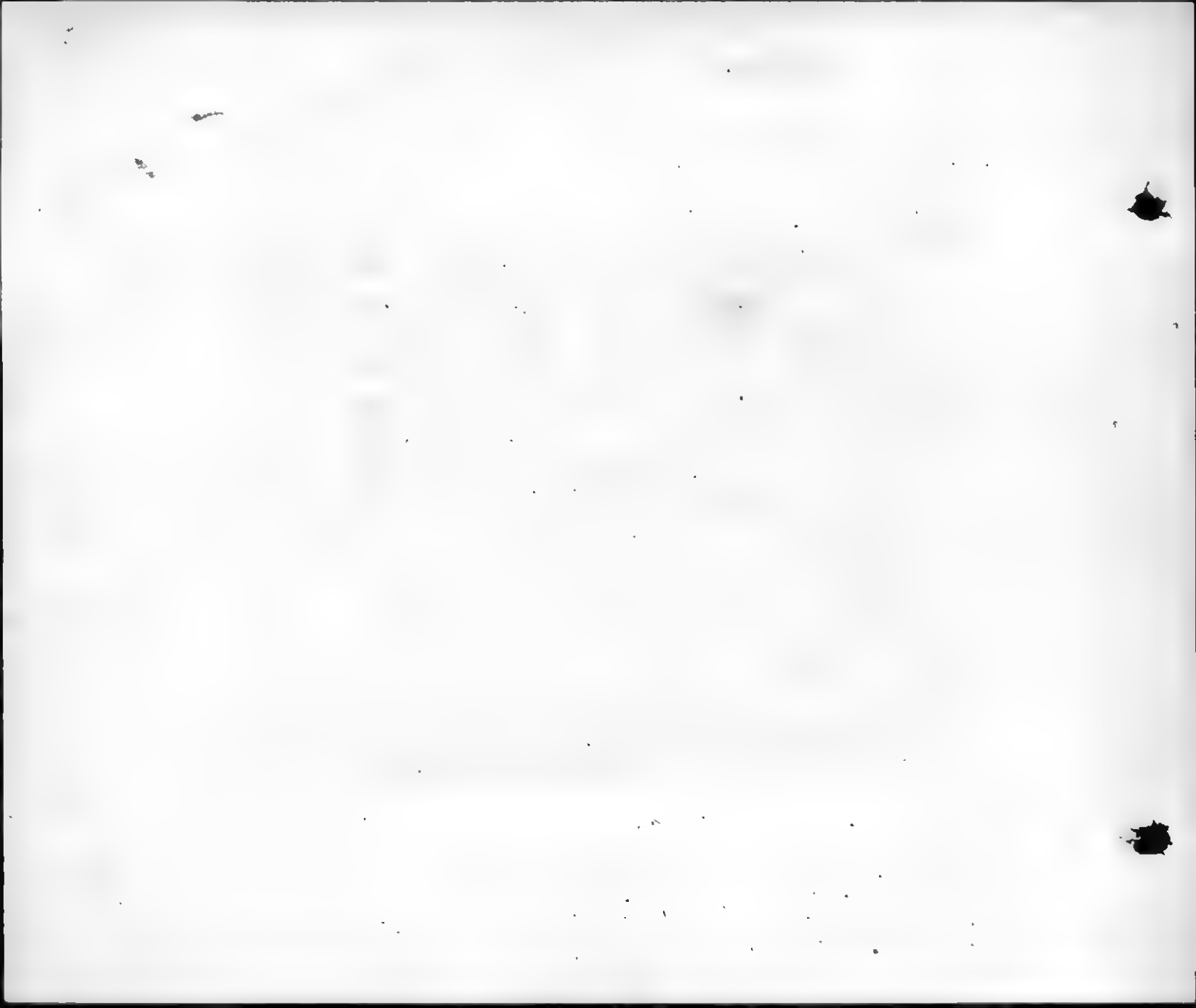
11669

Reg. Dist. No.

11530

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>19 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San'y Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Murtie</u> Middle <u>Alice</u> Last <u>white</u>				4. DATE OF DEATH Month <u>10</u> - Day <u>2</u> - Year <u>1959</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-21-1875</u>	
9. AGE (In years last birthday) <u>84 yrs.</u>		10. KIND OF BUSINESS OR INDUSTRY <u>1st wfr.</u>		11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Albert Buxton</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Hosp Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ant. Coronary Infarct</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH <u>one day</u> <u>years?</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 1</u> , 1959, to <u>Oct 2</u> , 1959, that I last saw the deceased alive on <u>Oct 2</u> , 1959, and that death occurred at <u>8:55 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A. Hare</u>				ADDRESS (Street, city or town, state) <u>7600 Carroll Ave, Takoma Park, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Robert A. Hare</u>				DATE SIGNED <u>10/2/59</u>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Oct 6-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Vincent</u>		22d. LOCATION (City, town, or county) (State) <u>Boulder, Colo.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u> ADDRESS <u>254 Carroll St NW. D.C.</u>				24a. REC'D BY REGISTRAR <u>DATE OCT 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur A. Hare</u>	

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11689

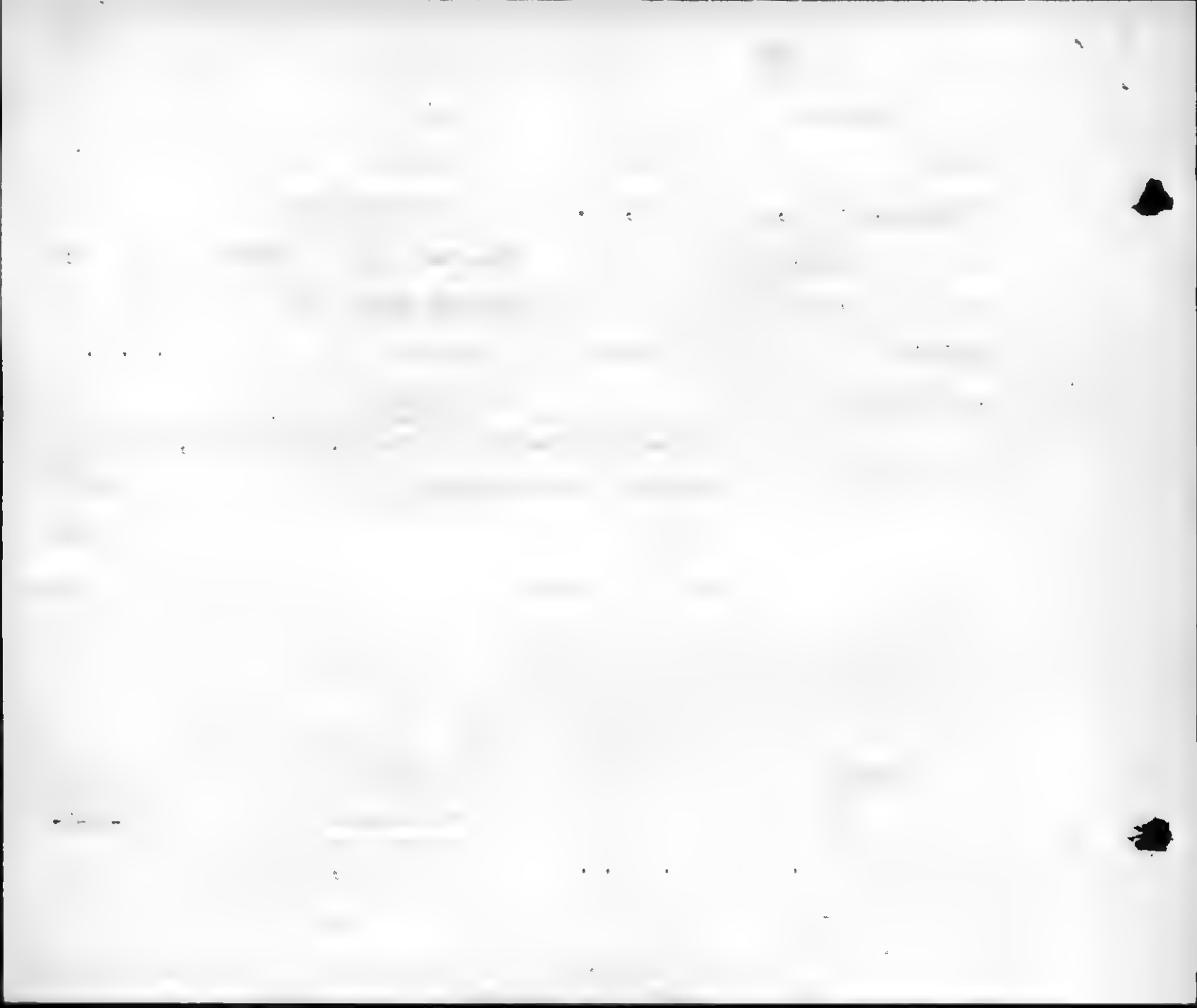
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Louisiana</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>4 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. STREET ADDRESS <b>(No street address)</b>			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>Ann</b> Last <b>Williams</b>				4. DATE OF DEATH Month <b>October</b> Day <b>24</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>19 October 1925</b>	
9. AGE (In years last birthday) <b>34</b> yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Oklahoma</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Haydon Brown</b>				14. MOTHER'S MAIDEN NAME <b>Flora Powell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO <b>Unascertainable</b>			
17. MEDICAL RECORD Address <b>The Clinical Center, Bethesda 14, Maryland</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage into Abdominal Cavity</b> <b>173X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Anuria</b> DUE TO (c) <b>Metastatic Choriocarcinoma</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>36 hours</b> <b>? 6 months</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>October 20</b> , 19 <b>59</b> , to <b>October 24</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>October 24</b> , 19 <b>59</b> , and that death occurred at <b>7:35 a.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>10-24-59</b> NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>10-29-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Avoyelles Parrish La.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				24a. REC'D BY REGISTRAR <b>Oct 30 1959</b>		24b. REGISTRAR'S SIGNATURE <i>William J. Lewis</i>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





11690

## CERTIFICATE OF DEATH

Reg. Dist. No 215

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY In 1b <b>109 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>Jacksonville</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jacksonville</b> d. STREET ADDRESS <b>4741 Godwin Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Frederic George WILLIAMS</b>		4. DATE OF DEATH Month Day Year <b>October 29 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-11-19</b>
9. AGE (in years last birthday) <b>40</b>		10. IF UNDER 1 YEAR Months Days Hours Min <b>40</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Navy</b>		12. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>	
13. BIRTHPLACE (State or foreign country) <b>Ohio</b>		14. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
15. FATHER'S NAME <b>William WILLIAMS</b>		16. MOTHER'S MAIDEN NAME <b>Edith LINDSEY</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		18. SOCIAL SECURITY NO. <b>WW II</b>	
19. INFORMANT <b>(Wife) Margaret Williams</b>		Address <b>Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Meningeal, intracranial</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12 July 19 59</b> to <b>29 October 19 59</b> that I last saw the deceased alive on <b>29 October 19 59</b> and that death occurred at <b>12:45 PM</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Adam T. Thorp, Jr.</b>		DATE SIGNED <b>U.S. Naval Hospital, Bethesda Md. 10-30-59</b>	
PHYSICIAN'S NAME (Type) <b>Adam T. THORP, Jr., LT, MC, USN</b>		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-1-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Clay Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Clay Center Ohio</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers</b>		24a. REC'D BY REGISTRAR <b>NOV 3 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Clayton S. ...</b>

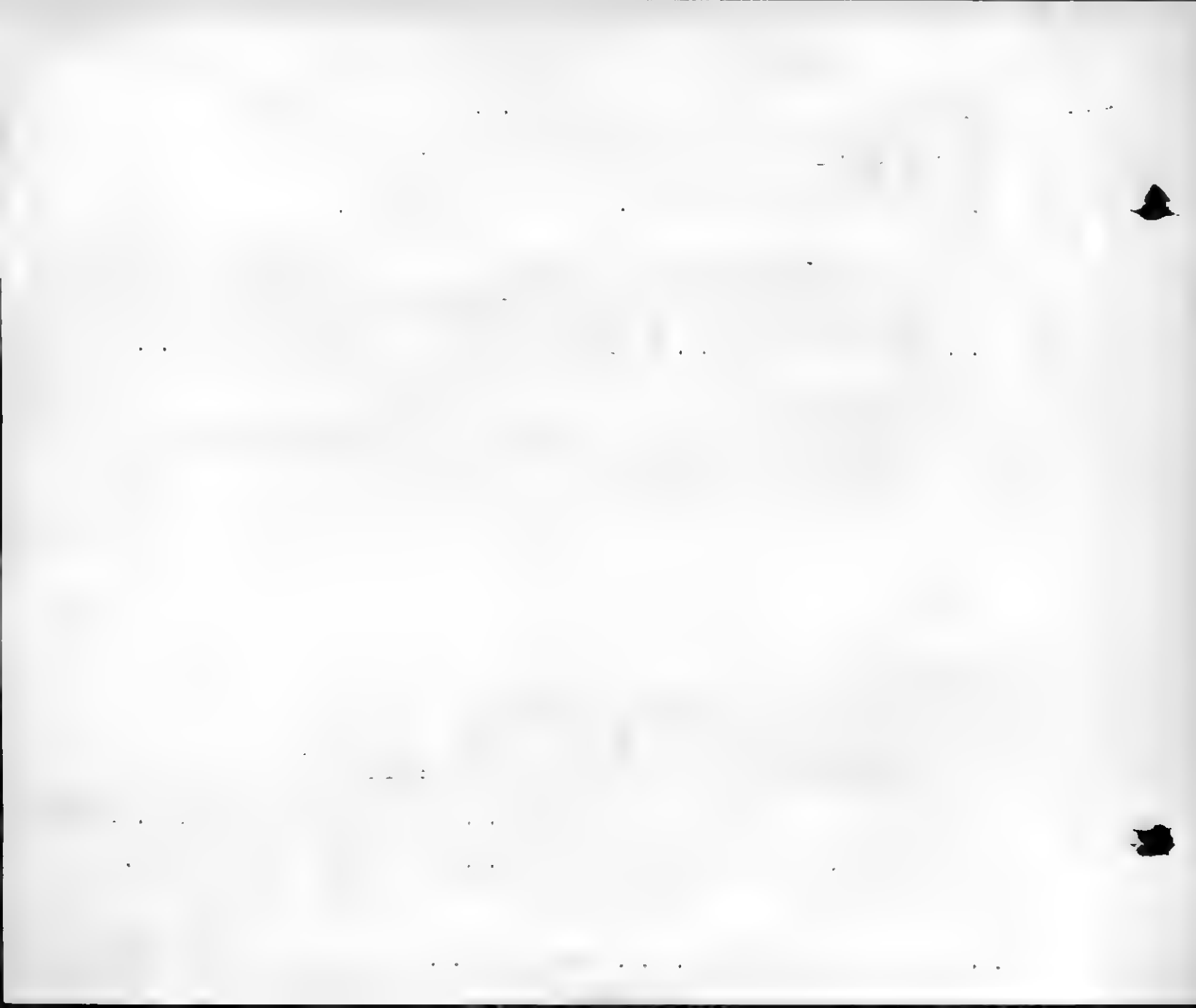
TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

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11691

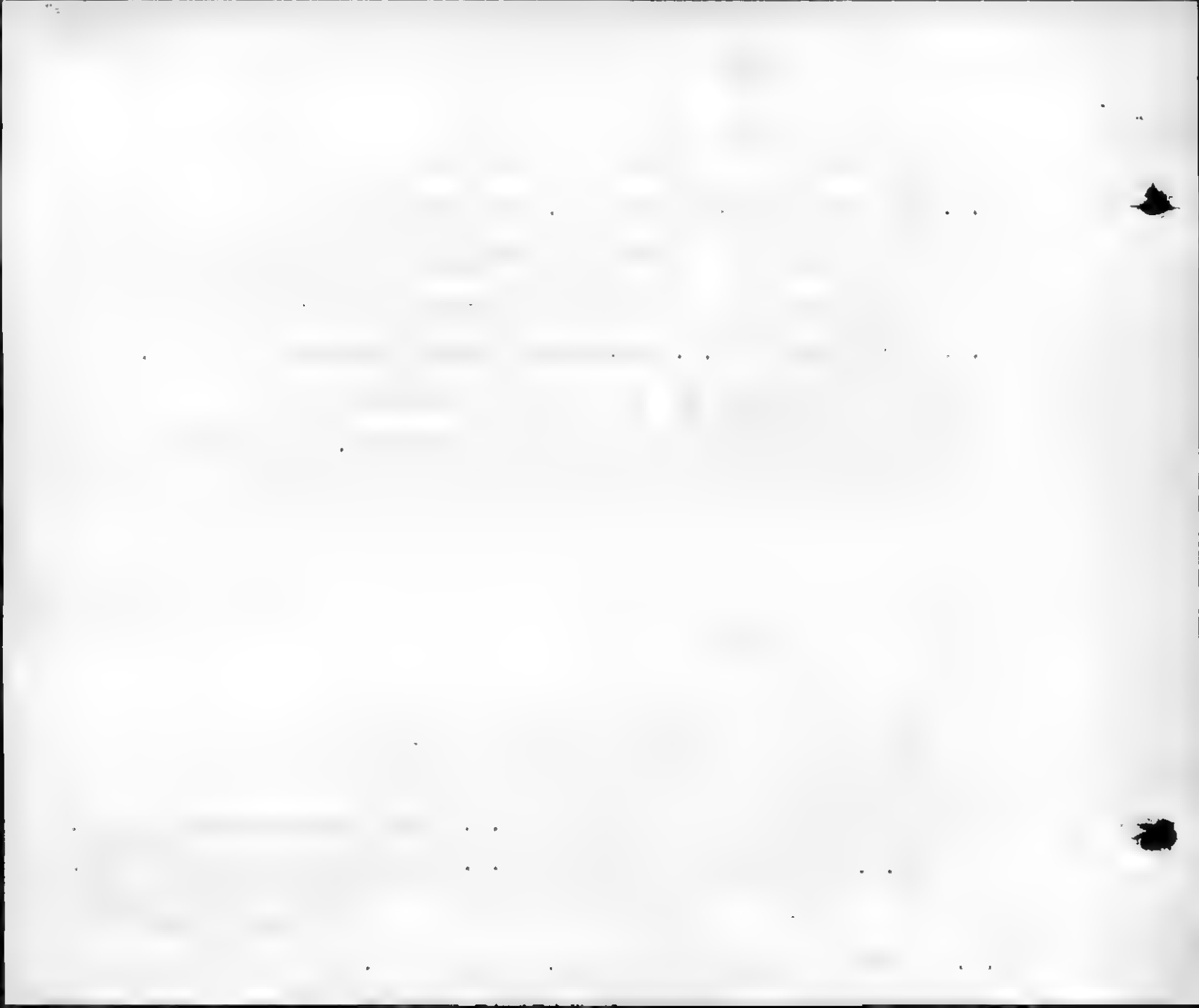
## CERTIFICATE OF DEATH

Reg. Dist. No 215

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>19 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Quantico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Quantico</b> d. STREET ADDRESS <b>210 Broadway Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Gar Angus WINGFIELD</b>		4. DATE OF DEATH Month Day Year <b>October 21 1959</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-14-10</b>
9. AGE (In years last birthday) <b>49</b>		10. IF UNDER 1 YEAR Months Days Hours Min <b>49</b>	
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Marine Corps</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Frederick WINGFIELD</b>		14. MOTHER'S MAIDEN NAME <b>Ella WYATT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW II</b>		16. SOCIAL SECURITY NO <b>228 05 1141</b>	
17. INFORMANT <b>(Wife) Minnie E. WINGFIELD</b>		Address <b>Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Lung with extensive metastases</b> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>metastases</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>2 October, 1959</b> to <b>21 October, 1959</b> , that I last saw the deceased alive on <b>21 October, 1959</b> , and that death occurred at <b>11:20 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda Md. 10-21-59</b>			
ACTUAL SIGNATURE <b>Gene Clenathan</b>		M.D. <b>U.S. Naval Hospital, Bethesda Md.</b>	
PHYSICIAN'S NAME (Type) <b>J. E. MC CLENATHEN CDR MC USN</b>		<b>U.S. Naval Hospital, Bethesda Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-26-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Pumphrey</b>		ADDRESS <b>7557 Wisconsin Ave. Bethesda Md.</b>	24a. REC'D BY REGISTRAR <b>OCT 27 1959</b>
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

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11531

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TACOMA PATRIC</u>		c. LENGTH OF STAY IN 1b <u>2 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>		e. STREET ADDRESS <u>8607 CARROLL AVE</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>FREEDA SARAH Wolff</u>		4. DATE OF DEATH Month <u>10</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>F</u>	6 COLOR OR RACE <u>IN</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-1-13</u>
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HSW</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PA.</u>	
11. BIRTHPLACE (State or foreign country) <u>PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>SAMUEL DIAMOND</u>		14. MOTHER'S MAIDEN NAME <u>SARAH SILVER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>577-527858</u>	
17. INFORMANT <u>PATIENTS HOSP. RECORD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> <u>110X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of the breast</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-19-57</u> 19 <u>—</u> to <u>October 20, 1959</u> that I last saw the deceased alive on <u>October 20, 1959</u> , and that death occurred at <u>6:10 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Boris Rabkin</u>		ADDRESS (Street, city or town, state) <u>1019 University Boulevard Silver Spring, Maryland</u>	
M.D. <u>1019 University Boulevard</u>		DATE SIGNED <u>10/20/59</u>	
PHYSICIAN'S NAME (Type) <u>BORIS RABKIN</u>		<u>Silver Spring, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/21-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ches Shalom Memorial Park Wash.</u>	22d. LOCATION (City, town, or county) (State) <u>DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg</u>		ADDRESS <u>4217-928 NW</u>	
24a. REC'D BY REGISTRAR <u>OCT 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

MEDICAL CERTIFICATION

TO HOSPITAL: The attending physician: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11692

## CERTIFICATE OF DEATH

11675

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN 1b <u>3 months</u>		47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Congressional Manor San.</u>		d. STREET ADDRESS <u>1702 Kilbourne St.</u>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sparrel</u> Middle <u>A.</u> Last <u>Wood</u>		4. DATE OF DEATH Month <u>10</u> Day <u>2</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/30/1873</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State of Virginia Schools</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Johnston Wood</u>		14. MOTHER'S MAIDEN NAME <u>Judith Shortt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
INFORMANT <u>Cong. Manor Sanitarium Records</u>		Address <u>Bethesda, Md.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 331X DUE TO (b) <u>Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 hours</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Post operative Suprapubic prostatic resection BPH</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 5</u> , 19 <u>57</u> , to <u>Oct 2</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct 2</u> , 19 <u>59</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William D Oldham</u> M.D.		ADDRESS (Street, city or town, state) <u>915 - 19th St NW</u> DATE SIGNED <u>Oct 3, 1959</u>	
PHYSICIAN'S NAME (Type) <u>William D Oldham MD</u>		<u>915 19th St NW</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/5/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Washington Nat'l</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Brown Co.</u>		24a. REC'D BY REGISTRAR <u>2901 1/2 St. N.W. Wash, D.C.</u> DATE <u>OCT 2 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur G. Knappe</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

11581

Get the ...

11581  
11582  
11583

William D. ...  
William D. ...



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11673

11693

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VA</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Great Falls</u>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Patomar River</u>		e. STREET ADDRESS <u>1412 N. Hartford St</u>	
3. NAME OF DECEASED (Type or print) <u>James A. Woodbury</u>		4. DATE OF DEATH <u>10-24-1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-13-27</u>
9. AGE (In years last birthday) <u>32</u> yrs.		10. IF UNDER 1 YEAR: Months <u>10</u> Days <u>24</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gov. employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>S. Dakota</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Wallace C Woodbury</u>		14. MOTHER'S MAIDEN NAME <u>Inga Skavang</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>417-8-1111</u>	
17. INFORMANT <u>Wendell Woodbury</u>		Address <u>417-8-1111</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia by drowning</u> 915X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c).			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Reported to have planned suicide by jumping in Patomar R.</u>	
20c. TIME OF INJURY Month, Day, Year <u>10-24-1959</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Patomar R</u>	20f. (City or town) <u>Great Falls</u> (County) <u>Montgomery</u> (State) <u>MD</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>11-7-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Elizabeth's</u>		22d. LOCATION (City, town, or county) <u>Prince George Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Spencer - 1331 E. Howard Ave. Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 9 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11-28-83

STATE  
DEPT. OF HEALTH

1. Name of Deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of Birth: \_\_\_\_\_

5. Place of Birth: \_\_\_\_\_

6. Usual Residence: \_\_\_\_\_

7. Date of Death: \_\_\_\_\_

8. Time of Death: \_\_\_\_\_

9. Place of Death: \_\_\_\_\_

10. Cause of Death: \_\_\_\_\_

11. Manner of Death: \_\_\_\_\_

12. Signature of Medical Examiner: \_\_\_\_\_

13. Signature of Coroner: \_\_\_\_\_

14. Signature of Registrar: \_\_\_\_\_

15. Signature of Physician: \_\_\_\_\_

16. Signature of Nurse: \_\_\_\_\_

17. Signature of Undertaker: \_\_\_\_\_

18. Signature of Burial Place: \_\_\_\_\_

19. Signature of Funeral Home: \_\_\_\_\_

20. Signature of Cemetery: \_\_\_\_\_

21. Signature of Interment: \_\_\_\_\_

22. Signature of Burial: \_\_\_\_\_

23. Signature of Cremation: \_\_\_\_\_

24. Signature of Disposition: \_\_\_\_\_

25. Signature of Other: \_\_\_\_\_